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ABSTRACT

To study the effect on physically handicapped children's mental health of organized group activities in community centers and settlements, 230 children participated in a 2 year demonstration project. Mental health was defined as the child's social functioning in home and school and as reflected in the child's self image; and it was hypothesized that the mental health of mildly physically handicapped children improved through recreational activities with their nonhandicapped peers. It was also speculated that no special or additional staff would be needed. Data was obtained through interviews with the children, families, teachers, group leaders, and placement counselors. Researchers felt that, after comparing factors concerning the families, the school and the children's self evaluations, the children showed improvement attributed to associating with their nonhandicapped peers. The second hypothesis concerning staffing was not confirmed. Recommendations for community centers, schools, and adult education to benefit the mental health of physically handicapped children were made. (CD)

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NEW YORK SERVICE FOR THE HANDICAPPED

CHILDREN TOGETHER

The Effect of Integrated Group Experiences on Orthopedically Handicapped Children

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Harold W. Robbins
Project Director

January 1971

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The Effect of Integrated Group Experiences on Orthopedically Handicapped Children

A Final Report to
the National Institute of Mental Health
for Research Grant No. R11-MHO-1604

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PREFACE

The original design for this study was the responsibility of Dr. Carl Wells who resigned shortly after completion of the last phase of the agency's experimental pilot program to integrate orthopedically handicapped children in neighborhood community centers. In July, 1965, I joined the staff to become research director of this demonstration-evaluation with major responsibilities for the latter.

Mr. Harold Robbins was project director throughout the demonstration and during the initial phase of the analysis of center findings. His illness prior to completion of the data analysis prevented his participation in the overall analysis and final report. He was responsible for the adminstration and supervision of the demonstration. This involved casefinding, center finding, the interpretation of the study to the community centers and referral agencies, the screening procedures to determine eligibility, and supervision of the activities of the placement counselors throughout the two years of the demonstration. He also evolved an instrument for assessing the programs of the centers within the framework of the demonstration.

Mr. Robbins brought considerable experience to the demonstration through having directed the agency's pilot program from 1962-1965 which was valuable preparation for this study. The agency and I regret that his illness prevented his being able to work on this final report. He cannot be held responsible for the interpretation of the findings, the conclusions or the recommendations.

Accordingly, the findings, interpretations, conclusions, recommendations, and implications of this study are my responsibility with the full cooperation and assistance of Dr. Merygold V. Nash, the executive director of the agency.

January, 1971
Great Neck, N.Y.

Celia S. Deschin
Director of Research

ACKNOWLEDGMENTS

It is seldom possible to acknowledge adequately all the assistance generously provided during the course of a complex study involving so many individuals in different aspects of the research. This is made more difficult since the study was initiated prior to the writer's assumption of responsibility for the research aspects in June, 1965.

To the Board of Directors of the New York Service for the Handicapped go my thanks for their unstinting interest and time as well as financial support for the study when the need for service almost overshadowed the need for evaluation of a demonstration based on the agency's innovative pilot program that made NIMH support for this study possible. Accordingly, to the Board Members, I am deeply grateful and take this opportunity to thank them publicly. To Mrs. Leon Weil, Chairman of the Community Services for Children Board Committee, go special thanks for her keen interest, thought - provoking questions and supportive understanding of the task I had assumed.

To the project's Technical Advisory Committee, whose acceptance of the changes in the research design and whose challenging questions, coming as they did from knowledge sources different from mine, were a constant stimulus, I wish to express professional gratitude and personal thanks.

To the 45 community centers whose personnel made it possible for the study children to be placed in group activity programs and who provided the essential reports of their progress, I wish to offer my sincere thanks for their co-operation in this, the first comprehensive study of its kind. Had it been possible for Harold Robbins to have been involved in the preparation of this final report, I am sure that he would have joined me in expressing his thanks.

To the large and varied project staff, I wish to express my personal thanks for their dedicated concern in carrying out their responsibilities which, for the research interviewers, meant visits to the families and children, evenings and weekends, in neighborhoods that were already becoming somewhat hazardous to visit. To the rest of the staff, goes my sincere appreciation for their willing assistance which made my task both more meaningful and more efficient.

To Elvin Cheatham go my heartfelt thanks and deepest appreciation for the painstaking care she has given to the preparation of this final copy, especially since the draft provided her would have tried the patience of a person less devoted and less competent.

These acknowledgments would be incomplete if I did not pay special tribute to the 230 families and their 230 orthopedically handicapped children, as well as the siblings, without whose active participation there would have been no study.

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---

*Left New York City before completion of Project

**Moved during Project period to Big Brothers, Inc.

THE 45 COMMUNITY CENTERS AND RECREATION FACILITIES

Bronx -	* James Monroe Community Center
	* Bronx House
	* Bronx YM-YWHA
	* East Side Houses (Mill Brook)
	* East Tremont YM-YWHA
	* Bronx River YM-YWHA
	* Riverdale Neighborhood Association
	* Claremont Community Center
	* Bronx River Neighborhood Center
	* Board of Education After-School Program
Brooklyn -	Boro Park YM-YWHA
	Van Dyke Community Center
	* East Flatbush-Rugby YM-YWHA
	* Coney Island YM-YWHA
	* Kings Bay YM-YWHA
	East New York YM-YWHA
	* Stuyvesant Community Center
	Willoughby Houses
	* Pink Village Community Center
	* Williamsburgh Settlement House
	* South Brooklyn Neighborhood House
	Brighton Beach YM-YWHA
Manhattan -	* 92nd Street YM-YWHA
	* Lincoln Square Neighborhood Center
	* Morningside Community Center
	* James Weldon Johnson Community Center
	* University Settlement
	* Emanu-El Midtown YM-YWHA
	Washington Heights-Inwood YM-YWHA
	* Casita Maria Carver Community Center
	* Manhattanville Community Center
	* Jefferson Boys' Club
	Hudson Guild
Queens -	Flushing Bland Community Center
	South Queens Boys Club
	* Pomonok Community Center
	Girl Scouts of America
	Jacob Riis Community Center
	* Samuel Field YM-YWHA
	Gustave Hartman YM-YWHA
	Ravenswood Community Center
	Central Queens YMCA
	Cub Scouts of America
	Boy Scouts of America
	Sunnyside Jewish Community Center

---

*Centers with study children for 2 years of Project.

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CHAPTER I

THE RESEARCH PROBLEM:
OBJECTIVES, SCOPE, AND SIGNIFICANCE OF THE STUDY

The Children's Integration Study, co-sponsored by the National Institute of Mental Health,* was originally designed as a five-year demonstration to show the effects of integrated group activities in neighborhood centers on 6 to 12 year-old orthopedically disabled children. In addition to a study of their families, the original design included comparisons between the effects of segregated and non-segregated group experiences as well as analysis of the interaction between the non-handicapped and the physically disabled children. When funds from the National Institute of Mental Health were available for only a three year period -- to include demonstration and evaluation -- it was found necessary to omit some of the aspects of the research design even though there was matching financial support from the New York Service to supplement the government grant. Omitted regrettably were the study of the non-handicapped children and their parents as to the influence of shared activities with physically disabled peers; and the study of the effect of segregated versus non-segregated experiences. Otherwise, the basic research design so far as the inclusion of an experimental and comparable control groups remained unchanged.

A request to extend the analysis and evaluation phase of the demonstration was granted, making this a four-year study.

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*April 1, 1965 - March 31, 1969.

Objectives, Scope and Frame of Reference of Original Design

The two primary objectives in the original design were: (1) "to demonstrate a new method for improving the mental health of orthopedically disabled children through participation in group experiences with non-handicapped peers;" and (2) "to demonstrate that this method could be implemented successfully through the use of regular programs in existing community centers" (i.e. without additions, or changes in facilities and/or personnel).

In the first objective, the major hypothesis to be tested, the word "demonstrate" was changed to "seek" since the study designed was largely exploratory.

In view of the lack of consensus as to the meaning of the concept mental health, it was defined for the purposes of this study as the child's capabilities in social functioning. In addition, a focus on only specific aspects of a child's mental health to be evaluated seemed logical in view of the complexities -- anticipated and unanticipated -- inherent in evaluative research in a "social laboratory" involving growing children and the many factors in 45 community center programs over which the researcher would have little and, in some instances, no control. This required observation of changes in:

1) the child's self-image;
2) the home, with parents and siblings;
3) the school, with teachers and classmates; and
4) for the experimental group, the integrated recreation groups in the neighborhood centers.

Then followed assessment of these with clarity, objectivity and integrity in accordance with the goals of the demonstration, namely, to find out what has happened, how, and why, so far as the data will permit.

Evidence of changes, negative or positive, in a child's social functioning can be obtained from parents, teachers, center group leaders and from the agency's placement counselors with the possibility of obtaining some degree of consensus as to the direction of change for a time-limited period. Similarly, change in a child's self-image can be obtained through the home interviews which began prior to the experience in the center, i.e., change from "pre-existing condition".* The components of a child's social functioning can be more readily standardized and structured in observations and evaluations than can the components of his "mental health."

Another factor that stimulated this change was recognition of the large number of variables reflected in the study population of 230 children out of a total 520 children referred from orthopedic hospitals, clinics, and health classes who met the criteria for participation in the demonstration. Over and above the variables pertaining to age, sex, ethnic origin, type of disability and differences in the child's social situation, there were variables having to do with differences in types of class in school -- whether "health" or regular, or on home instruction; previous experience in some group activity; and differences in the community centers. These and other aspects of the design having to do with methodology are elaborated in Chapters III and IV.

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*Suchman, Edward A. "A Model for Research and Evaluation on Rehabilitation", Sociology and Rehabilitation. Marvin B. Sussman, Ed. December, 1965. pp. 55-65.

Other changes have to do with research philosophy. The original design reflected, as might be expected, the professional training and philosophy of Dr. Carl Wells, a psychologist, with an emphasis on obtaining data usually referred to as objective from persons who are viewed as respondents and/or subjects. The present approach reflects the professional training and research philosophy of this author, a social worker and social scientist, who views "respondents" as participants and who is committed to an emphasis on obtaining data chiefly through depth interviewing, even though such data may be considered subjective by some researchers. (The terms underlined have significance and relevance chiefly in relation to a specific study.)

During the latter part of Dr. Well's work with the agency, he was reconsidering the value of tests he had originally proposed in light of the lack of standardization, particularly for physically handicapped children in the age group included in the demonstration.

The changes can be summarized simply as a greater emphasis upon skilled interviewing and direct observation to obtain the primary data essential for an objective evaluation of the demonstration. Specifically, this has involved careful before observations of the children in the two areas in which it is to be expected that changes will occur: (1) in the child's relationship within the family, and (2) his behavior and functioning in school. Accordingly, it seemed imperative to have as an objective a picture of the child's social functioning in these two areas prior to his placement in a center, if at the end of the demonstration it was going to be possible to evaluate whether changes in the child's behavior and social functioning in either direction, positive or negative, could be attributed to participation in integrated group activities in community centers.

Approach to the Study and Frame of Reference

It should be noted that neither Dr. Wells nor the author was familiar through professional training and experience with the group service field. In the opinion of the writer this was, if anything, an advantage in light of what has since been learned regarding the lack of evidence in the group service field of an attempt to evaluate what the so-called normal child is expected to gain from participation in group activities with peers under supervision. At least there was no bias in favor of tendencies to prove that group activities were responsible for all indications of change in children at an age when they were expected to reflect change as part of the natural growth process.

Significance

It was anticipated that the demonstration would be of value to community centers, schools, hospitals and professional groups concerned with orthopedically handicapped children. The choice of community centers was logically dictated by several considerations. Community centers, within their usual functioning, possess many of the necessary ingredients of the treatment method under investigation, namely, a suitable physical plant; recreational and social activities; non-handicapped children within the required age range; and trained and experienced supervisory staff.

These agencies are committed to serving their communities by policy and fund-raising and have operated for the last eighty years in a variety of ways. They have worked toward their objectives by providing a wide range of leisure-time activities, clubs, and classes. In addition, they frequently have played a leadership role in working for community improvement; they are important social institutions, dedicated to maintain community health through programs for individuals, families and the community at large.

Despite the objectives of community centers as outlined above, it was found that there were few centers actually serving the orthopedically handicapped prior to the beginning of a pilot program of the New York Service in 1959.* Considerable effert had to be made to ensure the participation of handicapped children and to gain permission from the parents.

The following factors appeared to be most significant in the failure of centers to serve the handicapped:

1. concern of the center that the handicapped would be more likely to have accidents;
2. reluctance of the parents of handicapped children to apply for membership because of a fear of rejection by the center;
3. lack of finances and experience of the centers with respect to transporting handicapped children;
4. concern of centers that their regular membership might object to the handicapped;
5. a lack of special physical facilities in the centers such as ramps and elevators;
6. anxiety on the part of the administrators and group leaders about working with handicapped children.

The secondary objective of the project was to demonstrate whether the obstacles referred to above could be overcome.

---

* This is described in Chapter II.

Additional questions with which the study was concerned were:

- What is the attitude of community center personnel toward serving orthopedically handicapped children?
- What changes were observed as a possible result of participation in the project?
- What was learned that would facilitate effective casefinding and referral techniques for placement of orthopedically handicapped children in community centers?
- What predictive criteria can be developed for the selection and placement of these children in community centers?
- What additions to existing knowledge regarding behavior and adjustment of orthopedically handicapped children and their families could be found?
- What guidelines in form of a manual could be developed that may be helpful to communities?*

This study has significance in a number of additional ways in providing answers to the following questions: Did it help the parents of handicapped children to establish contacts with parents of "normal" children? (Parents of handicapped children usually have little in common with parents of "normal" children since the two groups of children do not attend the same classes. Also, many of these parents are either ashamed to have their children associate with the handicapped, or are fearful lest the disability be contagious. Through their child's participation in the community center they will then have new opportunities to share common interests and develop relationships with their neighbors.) Will the findings stimulate schools and hospitals serving orthopedically handicapped children to consider the use of community centers as resources in the rehabilitation of these children?

---

*Unfortunately we were unable to prepare the manual due to the illness of the Project Director.

Answers to the foregoing questions are of special significance in view of the persistence of stereotypes concerning the social potential of physically disabled children, using the term "social" to include intellectual and creative capabilities -- stereotypes that limit opportunities available to them. This lack in turn makes for neglect of this group.

The Need for Understanding of the Physically Handicapped

Stereotypes flourish where knowledge is lacking. This is as true of attitudes toward minority groups generally as of the orthopedically handicapped. In this report, the term "orthopedically handicapped" is used interchangeably with physically disabled, though disabled in most cases is the more accurate term. It is also more descriptive for it is the lack of opportunity together with prevailing stereotypes that usually create the major handicaps. Moreover, in the literature, handicapped is used all too often to describe a wide variety of disabilities, including blindness and mental retardation.*

We are living in a period in which atypical children, children with a variety of handicaps, are slowly coming into their own

---

*The New York Times (Sunday, February 26, 1966) "Wheelchairs Are No Handicap to Students at Southern Illinois", provides a graphic illustration of the degree to which physical disability does not need to be the kind of handicap that is still all too prevalent, in particular, in the educational field, beginning with elementary school. The article notes that "stepless campus paths, beveled curbs, ramp entrances, elevators in new buildings, lowered telephones and drinking fountains, modified dormitory rooms and even special bathroom facilities, have made it possible for approximately 300 students with severe physical disabilities to attend classes. It is a matter of values as to which priorities are lavishly or niggardly funded."

-- some groups more slowly than others. Among the slowest to take their rightful places are the orthopedically disabled. Major questions for twentieth century America to answer -- questions which are central to the hypotheses which this study tested -- are:

> How to substitute knowledge for ignorance, thereby dispelling prevailing stereotypes, for example, that all who have physical disabilities are emotionally disturbed and/or retarded.
>
> How to teach people to accept individual differences as neither inferior nor superior but as a source of our national wealth -- human wealth.
>
> How to change the prevailing concept of beauty, usually exemplified by outward appearance, so that physically disabled children and adults are not stared at, feared, pitied and yes, even looked down upon.
>
> And, finally, how to provide for each child those opportunities that will enable him to develop his unique potential.

We have only a beginning understanding of the psychological wounds inflicted upon such children, their parents and their siblings through the persistence of the stereotypes and lack of opportunity. We have too little understanding of handicaps imposed by societal attitudes that are not only sanctioned by our culture but are institutionalized in our schools and in our community agencies and organizations. These handicaps, essentially obstacles, are then perpetuated by lack of facilities which would compensate for the physical disability and help these children to realize fully their potential.

Is it fear that has frozen us in an unresponsive attitude towards the disabled -- a fear handed down historically, based on ignorance of the causes of physical disabilities? If so, we will have to find a new basis for our fear. The availability of knowledge of the causation of physical disability removes this rationale which had some justification in earlier civilizations when the causes were largely unknown and the physically handicapped were feared, despised, and isolated because they were thought to be associated with evil. No longer is there any basis for the persistence in the United States of these age-old stereotypes, kept alive by our quasi-irrational worship of physical beauty -- often superficial and unrelated to beauty of the whole person, or to potential social usefulness.

In the sense that we all have differences in potential and limitations, we are comparable to the physically disabled, except that our shortcomings may not be visible, may not impede our mobility, or make our appearance generally unacceptable.

This report is concerned with the results of a demonstration that shows how the study children functioned when placed in community centers with their non-handicapped peers in programs where they were in the minority. The fears of the executive and administrative staffs and board members of these centers that admitting physically handicapped children to their programs would cause concern on the part of families of their non-handicapped members, loss in membership, and more accidents did not materialize. Although black and Puerto Rican families made up two-thirds of this study population, the professionals in a variety of social welfare fields and in our public schools understand too little and seemingly care little about these children. As yet, there is much to be done nationally in the way of pressuring for more understanding, more acceptance, and, in particular, more opportunity for the self-realization of physically disabled children who are human beings, each unique in his own way.

How many more physically disabled children are destined to become socially handicapped adults because they have been denied opportunity for educational and employment opportunities appropriate to their capabilities, doomed to live removed from the mainstream of life unless their families are wealthy and can provide them with opportunities for self-fulfillment?

The study findings point up the serious gap that remains between the "Bill of Rights for the Handicapped Child" that was projected as a goal for the 1930 White House Conference on Children and Youth and the "rights" currently available to this group of children, especially if they are in families of low-middle or lower socio-economic status.

> The handicapped child has a right to as vigorous a body as human skill can give him; to an education so adapted to his handicap that he can be economically independent ... to be brought up and educated by those who understand the nature of the burden he has to bear ... to grow up in a world which does not set him apart ... to a life ... which is full day by day ... with companionship, love, work, play, laugher, and tears - a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement.*

We are approaching another White House Conference four decades later. Will there even be cursory mention of the rights of physically handicapped children? The study findings suggest recommendations to bridge this wide gap of long duration between reality and the ideal expressed in the 1930 White House Conference.

---

*White House Conference 1930. Addresses and abstracts of Committee Reports, p. 291-292.

CHAPTER II

BACKGROUND OF THE PROBLEM

This study is the outgrowth of more than six decades of pioneering by the New York Service for the Handicapped* in providing services for the orthopedically disabled including an experimental pilot program for six years (initiated in 1959 by Dr. Melvin Herman) that made the present study possible. This organization is a voluntary, non-sectarian, interracial social agency with roots dating back to the turn of the century when persons with physical handicaps, even those considered mild today, were generally considered uneducable and unemployable. The agency experimented in new ways by which handicapped individuals might be able to fulfill their own potential, and sought to demonstrate to the community that disabled persons are human beings with normal drives, intelligence and normal capacity to lead socially productive lives.

The first experimentation in organizing services for physically handicapped children was The Crippled Children's East Side Free School incorporated in 1906. The school offered kindergarten and elementary classes, manual training and jobs in a workroom. It had a revolutionary feature -- a playground on the roof which could be used summer and winter, owing to the large adjustable windows which surrounded the play area.

---

*Formerly the New York Service for Orthopedically Handicapped.

> "The roof playground was open to neighborhood children for summer recreation in co-operation with the Board of Education, Madison House, and Henry Street Settlement. Along with this innovation, the school also introduced a completely equipped infirmary with a competent medical staff."*

The workshop for handicapped young men featured bookbinding, box making, metal and cement work and sign making. The girls' work featured fine hand sewing, embroidery, eyelet work and monogramming. The young men's workshop closed with World War I and the young women's shop continued until World War II.

Among the many activities of the school was the formation of a parent group which was successful for many years in fostering community interest in the school and the workroom. Out of this first school grew the camp for handicapped children at Oakhurst, New Jersey, which is still functioning, having expanded in 1956 to include adults. The Crippled Children's East Side Free School closed in 1938. In 1941 the name of the agency was changed to New York Service for Orthopedically Handicapped. During the forties, the agency returned to the education field to conduct a project to demonstrate that cerebral palsied children were educable and should be admitted to the regular schools.

Finally, the Board of Education agreed to accept responsibility for the education of these children and established "Health Classes" in various schools throughout the city in the early 1950's. By 1952, support from New York Service was no longer necessary.

---

*Glenn G. Drover, unpublished thesis for the Degree of Master of Social Work. Rehabilitation: A New Focus for Community Organization, Fordham University, New York City, 1965.

In 1958, a further expansion of the summer program was the organization of Teen Tours to provide bus trips of two weeks for handicapped teenage boys and girls and their counselors. They travelled through such areas as upper New York State, New England and the Pennsylvania Dutch Country. They stayed at motels along the way and took in all of the usual tourist attractions, together with summer theatre. These tours were most successful. They were sponsored through a private donation and unfortunately after eleven tours had to be discontinued in 1965 through lack of further funding.

In 1959, two new programs were initiated by the Board of the New York Service. One was to provide foster homes for physically handicapped adults who were unable to leave institutional living or who faced hospitalization for lack of a home. In 1961, this program became a five-year research project, co-sponsored by what was then the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare.* The other program was to provide physically handicapped children an opportunity to have a recreational experience with their non-handicapped peers.

It is interesting to note that the agency once again has entered the education field with the establishment in 1965 of the Alexander School for young handicapped adults who lacked the chance in earlier years to obtain an adequate elementary or high school education.

---

*The report of this project, made available in 1967, was written by Howard D. Young, Ph.D., Research Director.

It will be noted that all of the programs and projects that have been carried out by the agency in its almost seventy year history have been segregated in the sense of serving only the handicapped. Even though many mildly handicapped children have been encouraged to go to "normal" camps and indeed have been referred there, no actual follow-up was ever conducted to see whether the children were in fact able to cope in a less protected setting. Also, the foster home program brought handicapped adults into the maintstream of community life so far as living arrangements were concerned, but most of the young people sought work and recreation in a segregated program. This was not due entirely to the handicaps, but to societal attitudes, and not to lack of acceptance in particular cases.

Therefore, the agency's decision to participate in a project intended to integrate handicapped and non-handicapped in recreation groups was a step forward in service planning. Its desire to widen the scope of service to include more types of handicaps is in evidence in its second change of name, in 1969, to New York Service for the Handicapped.

A stimulus for the agency's pioneering demonstration has been the awareness that physically disabled adults and children are condemned needlessly to living in environments that restrict their lives by denial of many social, recreational, educational and vocational opportunities. And in a period when society has been made acutely aware of the problems of mental health, there is a heightened tendency to consider the effects of this denial as a defect in the individual rather than to seek out causes in the denial of essential opportunities for "normal" living.

The idea that community centers could extend themselves to provide recreation for the handicapped did not originate with the New York Service. As long ago as 1953 and 1954, the United Cerebral Palsy, Inc. of New York City was conducting segregated groups of cerebral palsied children in community centers.*

Then in 1955, the Community Council of Greater New York conducted a recreation program for orthopedically handicapped children in existing neighborhood centers and settlement houses. The program lasted until 1959 and served 33 elementary school aged children in 6 group work agencies. The project was not directed towards the problem of integration, in fact, most of the children attended segregated groups in the centers. The major concern was to demonstrate that the center had facilities that the physically handicapped could use, and that therefore, these children should be able to participate in center programs, even if in separate groups from the non-handicapped.

This pilot project did demonstrate that it was possible to serve the physically handicapped in these facilities. Recommendations for additional research, which constituted the major findings were the need for:

1) research of group work in action;
2) identification of better methods for evaluating the effects of group work;

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*Ernest Weinrich (Unpublished) Annual Report of Group Work Activities, September 1955 to August 1956: U.C.P. of New York City, New York, 1956.

3) techniques and development of guideposts for success in grouping the handicapped;

4) development of better methods of enlisting the support of voluntary organizations serving community recreation needs;

5) planning a program of orientation and education for workers not experienced with the handicapped.

(These last 2 were an integral part of the experimental pilot that New York Service initiated in 1959 when it began integrating orthopedically disabled children into regular community recreational programs.)

The first steps in the agency's 1959 pilot demonstration were to locate physically disabled children interested and able to take part in these programs. Among the first children found were some known to New York Service's Camp Oakhurst. By 1960, 18 such children were integrated into 10 community centers in Manhattan. By the end of the pilot, 371 orthopedically disabled children had been placed in 56 community recreation centers in Manhattan, Brooklyn, Bronx, and Queens in the six-year period, 1959-1964, that preceded the NIMH sponsored demonstration.

In 1960, Mosholu-Montefiore Community Center in the Bronx, a member of the Associated YM-YWHA of New York City, approached the New York Service seeking referrals of orthopedically handicapped children for the Center's regular program. This led to a program in the 1961-62 season, sponsored jointly by the two agencies with a Committee that included members of both Boards of Directors. Meanwhile, the Association of the Aid of Crippled Children gave funds to the Mosholu-Montefiore Center for a survey that was conducted by the center to ascertain the need for a larger program for handifapped children.

The joint project aimed at serving 25 orthopedically handicapped children in regular programs. New York Service provided funds to assist with costs of transportation and additional leadership. Both agencies reported that this joint project was successful as there was evidence that the children and their parents wanted the program to continue.

During the spring of 1962, Mosholu-Montefiore Community Center applied for a grant from the Children's Bureau without discussion with the New York Service. The plan of the application was for a demonstration involving a small group of children placed in their center on an integrated basis. They began with 25 and added more children throughout the study.* Since the group included a wide variety of handicaps not restricted specifically to children with orthopedic disabilities, its relevance to the present study is minimal.

When funding was granted by the Children's Bureau to Mosholu, there was no further basis for joint efforts. Nevertheless the New York Service continued to respond to Mosholu's request for help with casefinding. This left the New York Service free further to develop its own program which it had initiated in 1959 as mentioned earlier. This pilot program included efforts to interest more community centers in serving physically disabled children in their regular programs as well as to develop a research proposal for a grant from the National Institute of Mental Health.

To insure maximum effectiveness in casefinding, effective working relationships were initiated with several agencies.

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*Douglas Holmes, A Study of the Problems of Integrating Physically Handicapped Children With Non-Handicapped Children in Recreational Groups. Final Report. Mimeographed Copy, March 1, 1966.

Comparable working relationships were developed with the Bureau for the Education of the Physically Handicapped of the New York City Board of Education and with the Division of Physically Handicapped of the New York City Department of Health. In addition, functioning relationships were worked out with many New York City hospitals for referrals of physically disabled children, based on their medical summaries. Cooperative relationships were likewise established with the following organizations concerned with one or more aspect of the agency's objective of establishing integrated programs for the physically disabled: United Cerebral Palsy, Inc,; Association for Aid to Crippled Children and Adults; New York City Society for Crippled Children and Adults; Comeback, Inc.

The experimental programs briefly described above together with New York Service's pilot program of integrating 371 children in 56 community centers or settlement houses and its background knowledge of the orthopedically disabled gained through its long history of serving this group of children and adults provided the agency with valuable empirical data upon which to begin a more extensive demonstration and evaluation than would otherwise have been possible.

In summary, efficient organizational structure and techniques had been tested and developed to initiate casefinding and placement. Sound professional relationships with hospitals, social agencies, community centers, the Board of Education and the Department of Health had been created. A strong foundation on which to design and carry out an effective research project had been established prior to submitting an application for a grant to the National Institute of Mental Health.

CHAPTER III

FINDING THE STUDY POPULATION

It is indicative of the widespread attitude and lack of concern with physically disabled children described in Chapter I that the efforts detailed below had to be expended to interest and obtain the study population. These efforts also illustrate a prevailing attitude on the part of professionals involved in a variety of aspects of helping physically disabled children and especially hopital social workers. There has been little interest in exploring the possibilities for these children to have opportunities for activities with their non-handicapped peers by finding out:

1) whether physically handicapped children can make constructive use of services and experiences currently available, even though these may be in some cases on a very minimal basis;

2) whether additional services for them might be stimulated.

Nowhere is this attitude more graphically illustrated than in health classes in New York City's public schools where ramps, elevators and other structural changes would make it possible for many of the less severely handicapped to be in regular, rather than in segregated classes. This is not to overlook the many dedicated teachers of health classes who did their utmost to bring out the potential of the study children and who were frank to admit the problems and delays in transfer to a regular class when a child's physical functioning and mobility improved.

In December 1964, before official acceptance by the National

Institute of Mental Health of the grant application, the following steps were taken to initiate casefinding for the study:

1. An announcement and brief summary of the project was sent to all major New York City newspapers and social agencies.

2. A similar announcement with instructions and referral forms was sent to the following:

   a) All hospital and clinics serving the orthopedically handicapped in New York City. (Staten Island was not included due to the lack of any cooperating community centers.)

   d) Bureau for the Education of the Physically Handicapped of the New York City Board of Education.

   c) Camps for the orthopedically handicapped in the New York Area.

3. A current list of all health classes in the City School system was secured from the Board of Education.

4. Visits were made by the agency's field staff to supervisory personnel at the Board of Education and to selected hospitals. These visits were for the purpose of interpreting the agency's program and soliciting cooperation in the proposed demonstration.

By far, the most effective casefinding occurred as a result of direct visits to health classes -- a procedure that had been utilized and had proved effective during the earlier phases of the agency's experimental program to place physically handicapped children in selected community centers with non-handicapped peers. Specifically, the field staff would visit a given health class, interpret the program to the teacher and observe the children in class. In discussion with the teacher, children who seemed to qualify on the basis of the major criteria outlined below were given a letter to their parents describing the program together with a card that was to be returned to the teacher if the parent were interested. This procedure was necessary since the Board of Education policy does not permit the names and addresses of any of its pupils to be given out.

From the mothers who responded to the teachers in public school health classes and from a few parochial schools, as well as from orthopedic hospitals and clinics, camps serving orthopedically disabled cchildren and a variety of other sources such as private physicians, nursing agencies, and the Department of Health and the general public, an unduplicated list of 520 names was obtained. Of these, 150 were not interviewed because the referral information indicated that they were either too old, or too young; too handicapped, or retarded; or not orthopedically disabled. The remaining 370 children met the initial criteria according to the referral information. They were:

1) Boys and girls between the ages of 6 and 12.

2) Children with orthopedic disabilities visible to their non-handicapped peers.

3) Children who were not "homebound" or so severely disabled that in the judgment of the screening interviewer the child could not accommodate to the group, nor the group to him.

   (It was recognized that the handicapped children might not be able to take part in all of the activities, but this is also true of some of the non-handicapped.)

4) Children who were not already placed in a program of a group service agency or settlement house.

5) Children (and parents) who had shown interest in co-operating in the demonstration.

Then followed appointments for screening interviews in the home, the major objectives of which were to ascertain parental willingness to be part of the pilot demonstration as well as to assess the child's potential for participation in the demonstration. Other objectives were to obtain identifying information concerning the family and the child, including a detailed description of the child's physical and mental ability, as reported by the family and as observed by the screening interviewer, along with the interviewer's evaluation of the child's interest and readiness to participate in the demonstration.

An important part of the screening interview was an evaluation of the physical functioning level of the child. (See Disability Rating -- Chart I, p. 24) From information on the completed chart, each child was rated as functioning physically at a mild, moderate or moderately severe level. (It should be noted that none of the children was severely disabled, that is, having no ability to communicate or requiring total assistance in tasks requiring hand movements. Therefore, the term "moderately severe" is used with reference to "normal" children.) The Project Director had final decision regarding the eligibility of the study children.

The above casefinding procedures, which took from December 1964 to June 1965, resulted in a study population of 230 eligible children who met the criteria, had medical permission from hospitals or private physicians, and whose parents had indicated preliminary interest in participating in the 2-year demonstration.

Characteristics of the Study Population.

See Table I, p. 25) for distribution by sex, age, ethnic group, school class, disability rating and diagnosis.

CHART I

DISABILITY RATING*

	Normal Ability	Fair Ability	Minimal Ability(Needs some help)	No Ability(Needs considerable help)
A. Sitting Balance				
B. Standing				
C. Walking				
D. Speech				
E. Dressing				
F. Toilet Care				
G. Feeding				
H. Use of Hands				
I. Use of Feet and Legs				
J. Stair Climbing				
K. Running				
L. Hearing				
M. Seeing				
N. General Coordination				
O. Sitting Down				
P. Standing up				

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*Developed by Harold W. Robbins

T A B L E I

DISTRIBUTION OF THE STUDY POPULATION ACCORDING TO MAJOR CHARACTERISTICS

		TOTAL N = 230
		Percent
Sex:	Male	58.7
	Female	41.3
Age: (at beginning of Study)	7 and under	26
	8,9,10	55.7
	11,12	18.3
Ethnic Group:	White	37.8
	Negro	29.6
	Puerto Rican	32.2
	Other	0.4
Religion:	Catholic	52.6
	Protestant	25.7
	Other: Christian	3.9
	Jewish	14.8
	None	1.3
	No Record	1.7
School Class:	Regular	25.7
	Health	58.7
	Home Instruction	1.7
	No Record	13.9
Disability Rating:	Mild	44.3
	Moderate	47.0
	Mod. Severe	8.7
Diagnosis:	Cerebral Palsy	45.2
	Post-Polio	17.8
	Spina Bifida	3.0
	Muscular Dystrophy	2.2
	Disability in: Foot, Leg, Hip	19.6
	Disability in: Arm, Hand	3.0
	Brain Injured	1.7
	Other	7.4

Additional characteristics that are not included in the Table are described below:

Size and Composition of Family. This ranged from two (one parent and the handicapped child) to over nine in the household. The highest proportion, at least half of the children, were in households of four or five members.

Ten percent were "only" children. Approximately a third were middle children; an additional third were the youngest. In 23 percent of the families, the handicapped child was the oldest.

Marital Status of Parents. Over 70 percent of the children were living with both parents. Three children were living with parental substitutes. The remainder were living with their mothers and of these, 5.2 percent did not have legal marital status.

Educational Level of Head of Household. Fifteen percent of the children were in families where the head of the house had less than complete grade school education and at the other extreme, 14 percent were in families where the head had some, or had completed, college education.

Religion. The highest proportion were Catholic. Of the Catholics, the largest group was Puerto Rican. Approximately a third were Protestant, and of these, the largest group was Negro. Those of the Jewish faith accounted for 34 percent.

Residence. Brooklyn had the largest proportion of the study population (33.9 percent) with the Bronx, Manhattan and Queens following.

Housing. A small proportion of the entire group lived in one or two-family homes, most of them in Queens. By far, the largest number of families lived in an apartment or in low-income housing projects with less than a fifth living in tenements.

Income. Seventeen percent of the entire group had family incomes less than $3,000. At the other end of the range, about one-fifth had family incomes over $7,000; some well over this amount. The few upper-middle class white families in the study population had incomes far in excess of $7,000.

CHAPTER IV

COLLECTING THE DATA

What is usually referred to as data collection is essentially a process of obtaining meaningful and reliable information that will shed light on a significant social problem and, in addition, as in the case of this study, make possible evaluation of a demonstration. In this process it is essential that the problem under investigation be of interest and concern to those persons without whose active participation the relevant data, and hence, insight and understanding of the problem would not be possible.

Family Interview and Child Interview*

Depth interviewing was selected as the major research method because it is a tool of communication, par excellence, and because it is a distinguishing characteristic of research in the human relations field that participants can communicate, the researcher being a participant observer. This was an especially appropriate method for the Integration Study inasmuch as the interviewing took place in the home, with parents understanding in advance the importance of our interviewing the child alone. This was essential in many ways, for example, in making possible comparison of the child's feelings about his handicap, how it affected his social functioning at home and in school, with parents' views as to how the child felt about the handicap and its impact on his functioning. Examination of the interview schedules* used in the family and child interviews make clear the value of comparisons of these and other aspects in providing significant clues to the child-parent relationship. In addition, it was essential in order to test the study's major hypotheses to be able to communicate with the study children alone in order to obtain significant and relevant data by means of which to assess the status of their self-image.

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*Medical information was obtained on the 230 study children --- from clinics (92.6%) and private physicians (7.4%). Appendix p.A-40.

Both the first family interview and child interview took place before the beginning of the demonstration and before selection of the experimental and control groups. Accordingly, these first research interviews provided significant data essential as before measures, or as a base against which to assess direction of change, negative or positive, in the family situation, and, similarly, in the study child's self-image.

Differing Viewpoints Regarding the Validity of Interviewing.

There are different philosophies and viewpoints regarding research interviewing. It is the writer's view, based on considerable therapeutic and research interviewing that people participate more effectively in studies and provide more accurate information if they are considered as participants rather than "subjects" from whom information is to be obtained. This is of great importance since there is no methodological treatment to overcome limitations of a study's primary data. In this frame of reference, data collection becomes a collaborative process. It was, for example, assumed that if the participants understood and identified with the objectives of the research, they would be more likely to provide meaningful data of relevance to the problem under investigation. And training for the interviewers included ways of "reaching" the participants and many other related aspects of interviewing. It was also assumed that depth interviewing with largely open-ended questions in a comprehensive interview schedule was the most appropriate type of interviewing. It was planned to use the interview schedule from the first interviews (family and child) with minor changes and additions in Interview II and Interview III, on the assumption that because of the stigma, shame and generally negative feelings many parents of physically handicapped children have, due to the societal attitudes and behavior, it would take more than one interview for parents to be able to bring these feelings (which inevitably get across behaviorally, for example, through over-protectiveness) to awareness so as to create a more facilitating atmosphere in the home for the study child. The second set of family and child interviews took place at the end of the first year of the demonstration; the third set, at the termination of the demonstration a year later.

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*See Appendix

As regards the validity of interview data, the writer has long held the view that the interview as a method of research is neither valid nor invalid, per se. The validation depends upon such factors as: the problem to be investigated, the kinds of data relevant to the problem, the persons to be interviewed, and the qualifications, the training, and the skill of the investigators who utilize interviewing as a research instrument.[1]

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[1] Celia S. Deschin, "Psychiatric Casework Interviewing as a Research Method in the Human Relations Field", Journal of Psychiatric Social Work - April, 1953 (Vol. XXII, No. 3) pp. 128-134.

Depth interviewing requires of the interviewers skilled understanding of people in relation to a given situation, e.g., in this study, understanding of the meaning to a family of having an orthopedically handicapped child, and the meaning to the child of having a visible handicap. Also required are sensitivity to the interaction between interviewer and interviewee, including awareness of non-verbal communication, along with the ability to observe at the same time that the interviewer is engaged in listening and taking notes. Without the qualifications just described, research interviewing may be reduced to a sterile technique useful for obtaining superficial data on social problems or aspects of problems such as occurs regularly in the numerous opinion polls based on structured, precoded interviews and/or questionnaires. Accordingly, trained, experienced social workers were used for the interviewing in this study with the exception of the bilingual interviewers who had had training in anthropology.

Recently, too little attention seems to be placed on the qualification of interviewers and too much on preparation of precoded interview schedules and on the use of questionnaires based on preconceived notions of the range of responses. These are presumed to facilitate responses and their analysis. The following questions arise with respect to the use of questionnaires and of precoded questions in interview schedules (except for identifying data). If it is possible to anticipate responses before investigation of a problem, is the research necessary and is it likely to bring out new findings that challenge what is already known? Or is the research likely to be influenced to look for the anticipated answers?

At a national conference session devoted to a discussion of this type of interviewing, the writer formulated the following principles of interviewing in sensitive subject areas:

1. Most human beings -- adults or children -- are likely to share significant personal data at a time of stress.
2. There is a relationship between feelings of stress, reliability of the data, and the time required to obtain the data.
3. Interviewing skill is more important in assuring reliability of the interview data than is the structure of the interview schedule.
4. The interviewer has to be free from bias and have confidence in the capacity of the interviewee to provide understanding and insight into his life of the kind that cannot be obtained by so-called objective types of questions or precoded interviewing techniques. The interviewers' lack of confidence in the interviewees' ability in this respect can and does constitute a serious obstacle.[2]

This concept of research interviewing has, in addition, therapeutic value for the participants in enabling them to gain greater insight into their own lives at the same time that they make a contribution to research. This had special significance in the present study for parents of orthopedically handicapped children, almost two-thirds of whom were Negro or Puerto Rican.

The principles described above assume greater importance today in view of the widespread tendency to depend upon techniques of mechanical processing. As the writer indicated in a study in which IBM processing was utilized, "reliance on the latter has had the effect of imputing too much reliability and validity to statistical associations while too little attention has been paid to the importance of careful selection of units of behavior and environment for correlation. The status of today's knowledge of human behavior and its relation to and interaction with environment* is such as to make it necessary to recognize that such associations serve to provide clues to a deeper understanding of the relationship between social controls and behavior. They are seldom definitive."[3] Application of this concept to the present study is described and illustrated in Chapter V.

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[2] Celia S. Deschin: "Research Interviewing in Sensitive Subject Areas", Social Work, Journal of the National Association of Social Workers, April 1963, (Vol. 8, No. 2) pp. 19-23.

Assignment of Study Population to Experimental and Control Groups

As was planned in the study design, some of the 230 children had to be assigned to a control group. At the time of the initial research interviews with the families and children during the summer of 1965 this assignment had not been made. The Project Director and the Placement Counselors were still engaged in finding a sufficient number of community centers interested and willing to have a few handicapped children attend their programs. Both parents and children were informed that even though some children would be in the control or comparison group, their progress would be followed in the same way by visits to the home and to their teachers, and it was hoped that some opportunity for increased contact with non-handicapped children might later become available in their neighborhood.

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*This term is used here to mean the intimate family milieu as well as the larger social forces that impinge on the family.

[3] Celia S. Deschin, Teenagers and Venereal Disease: A Sociological Study of 600 Adolescents and 100 of their Families, United States Department of Health, Education, and Welfare, Public Health Service, 1961, p. 69.

The basis for assignment to the experimental group was the availability of an integrated group program within a reasonable distance from the study child's home. Of the 230 children, 60 lived in neighborhoods where community centers were not available and/or willing to include physically handicapped children in their programs. The logic of this decision was obviously based on anticipated problems in transportation if the child had to travel too far and the fact that friends made at the center would not be likely to be retained if the distances were too great.

Comparability of the Experimental and Control Groups

Although based, in part, on social work's philosophy in not withholding services in research projects, it is doubtful that a random selection, though more scientific than the basis used in this study, would have resulted in two groups much more comparable. (See Table 2, p. 34).

Sex and Age. In both groups there were more males than females, with a twenty percent difference in the Experimental group. It will be noted that in the Control group there were twice as many males as females. The median age was the same in both groups -- eight years, while the age range was from six to twelve.

Ethnic Grouping. In this respect the differences were minimal. The Control group had ten percent more whites, understandable since the Control families lived in Queens, the Borough that had a preponderance of white middle-class families.

Religion. The two groups were comparable in stated religious preference.

Educational Level of Head of Household. The differences here were not significent: slightly less than 50 percent in the Experimental group had completed High School, or went beyond, while only 36 percent in the Control group had graduated from High School and had some college education. The difference again reflects the larger proportion of middle-class families in the Control group.

TABLE II

CHARACTERISTICS OF THE STUDY POPULATION BY EXPERIMENTAL AND CONTROL GROUPS

		EXPERIMENTAL (170)	CONTROL (60)
		Percent	
Sex:	Male	55.3	68.3
	Female	44.7	31.7
Age: (at beginning of study)	7 and under	24.7	30.0
	8,9,10	56.4	53.3
	11,12	18.9	16.7
Ethnic Group:	White	35.3	45.0
	Negro	31.2	25.0
	Puerto Rican	32.9	30.0
	Other	0.6	-
Religion:	Catholic	51.9	46.5
	Protestant	27.8	32.6
	Other: Christian	3.8	2.3
	Jewish	15.2	16.3
	None	1.3	-
	No Record	-	2.3
School Class:	Regular	28.2	18.3
	Health	57.1	63.3
	Home Instruction	1.2	3.3
	No Record	13.5	15.1
Disability Rating:	Mild	47.6	35.0
	Moderate	45.9	50.0
	Mod. Severe	6.5	15.0
Diagnosis:	Cerebral Palsy	39.4	61.7
	Post Polio	21.2	8.3
	Spina Bifida	2.4	5.0
	Muscular Dystrophy	1.8	3.3
	Disability in: Foot, Leg, Hip	22.9	10.0
	Disability in: Arm, Hand	2.9	3.3
	Brain Injured	1.8	1.7
	Other	7.6	6.7

Functional Rating of Child's Disability. There were some differences in this respect: In level 1, mild, the Experimental group had 48 percent versus 35 percent of the Controls. At the other extreme, level 3, moderately severe, there were 6.5 percent of the experimentals as compared with 15 percent in the Control group. The two groups were practically the same for level 2, moderate.

Type of Class. A larger proportion of the Control group were in regular classes. The difference was minimal so far as health class was concerned, with the Control group having slightly more children in health classes.

Income. At the upper and lower ranges, the income difference was minimal.

Housing. The only significant difference was in the one-or-two-family homes, with a larger proportion in Queens (the Control group) where there is a larger proportion of white middle-class families. Approximately the same proportion in both groups lived in multiple dwellings.

Size of Family. The size of family ranged from two (one parent and the handicapped child) to over nine in the household, with the highest proportion, at least half of the study population, in households of four or five members. There was only a slight difference between the Experimental and Control groups.

Marital Status of Parents. Differences between the Experimental and Control groups in this respect were slight, although all of the families broken by death of parent, separation, desertion or divorce were found in the Experimental group.

Residence by Borough. Brooklyn had the largest proportion of the study population, with the Bronx, Manhattan and Queens following, in descending order. Since the Experimentals were selected on the basis of availability of a community center, it is not surprising that a larger proportion of the Controls were from Queens.

Approach to the Families. Since several months had elapsed since the screening interview on the basis of which the Project Director had made the decision as to eligibility, a letter was sent to the 230 families over his signature and that of the Research Director.* (Letter was also sent in Spanish.)

Following this letter announcing the beginning of the interviewing and at the time of the first research interview parents were asked to sign an agreement to participate, (See Appendix, p.A-37) which was available in Spanish as well. It should be pointed out that the agreement was signed before families were assigned to the Experimental or Control groups. No family was untouched by the participation in the demonstration. This was due in part to the fact that parents were made to feel that they constituted an important part of the study and were making a significant contribution to the study; to the quality of the interviewing; and to the kinds of questions included -- questions that made them think about, react to, and, in some instances, change their attitude toward the handicapped. These questions were repeated with minor modifications in three depth interviews encompassing the demonstration period.

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*See Appendix, p. A-38.

Following the first parent and child research interview arrangements were made with the Director of the Bureau for the Education of the Physically Handicapped in the Board of Education of the City of New York for permission to visit the schools and interview the teachers of the study children. The first time the research interviewers visited a particular school, the principal was interviewed briefly. Thereafter, only teachers were interviewed. One hundred schools in the four boroughs were involved.

Teacher Interview.*

It was planned to interview the child's teachers before the beginning of the demonstration; at the end of the first year and again at the end of the second year. The purpose of these interviews was to obtain data that would permit an assessment of another important aspect of a child's functioning, namely, the school. This was viewed as occurring in three major areas:

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*See Appendix p. A-2[illegible].

1) academic functioning, including the child's participation in class, the teacher's description of the child's potential and whether he was living up to this potential;

2) social functioning, e.g., with classmates, with clues as to the kind of relationship the study child had with peers whether in a health or regular class;

3) character of the child's relationship with his teacher as an adult figure and as the person who facilitated his learning and social development.

In each of the three aspects of the interview, the teachers were asked to give illustrations.

Other aspects of the teacher interview schedule had to do with parent contact with the school and the interviewer's observations and impressions, in particular, the character of the teacher's relationship to the study child.

There were minor changes in the second and third interviews, chiefly some condensation in areas that had not proved too productive in the first interview and questions regarding any change in the child's functioning in the three areas listed above. In other words, as in the case of the first family and child interviews, the initial teacher interview was used as a basis for assessing direction of change in the child's functioning in school. Obviously, these questions had a different relevance if the child had the same teacher throughout the two-year demonstration, than if he had had, as in some cases, three teachers. Nevertheless, insight into the child's functioning in school was made possible through analysis of the data obtained whether the child had a change in teachers or not.

The data thus collected broadened the base for observation of the entire study population. In other words, these data provided another social dimension outside the home for both groups as well as another independent observer's view of the study child's functioning in social setting. And for the control group, the school provided the only opportunity to observe the children in a group setting. Analysis and interpretation of these data are found in succeeding chapters.

The Group Setting: The Rehabilitation Variable.

The signifiance of this project is enhanced because it came at a time when the community centers and neighborhood houses were beginning to question the effectiveness of their role in the community. Change was and still is in the air. The particular needs of a neighborhood became more apparent as the people demanded more voice in the decision-making process. Group work agencies began to examine their program of services in relation to both the new demands and the changing needs. There was dawning recognition that large groups of people were not going to wait passively to be "reached" or to continue to be ignored in neighborhood planning. The community centers had to face a move to a neighborhood more in keeping with their accustomed way of operating or make a radical change in service policies. An important factor influencing the choice seemed to be whether they acknowledged that they had "missed the boat."

With traditions being challenged and minority groups being wooed, the New York Service began in 1959 to seek integration for a group that cut across all other minority group lines --

physically handicapped children. It was recognized that in many ways it is easier to reject the handicapped child "for his own sake" than to reject a child of a minority ethnic group. The director of a center* can point to the possibility of accidents, the inadequacy of staff, the lack of suitable physical facilities, the objections of parents of the non-handicapped members, and inexperience in arranging special transportation. His decision to reject handicapped children is reinforced by the reluctance of the parents of handicapped children to seek membership at the center, anticipating and fearing rejection. Since these parents are not pressing for service, the director can comfortably state that there are not many handicapped children in his community, and that those who are there are too severely handicapped to participate in program or he would have heard from the parents!

Following up a six-year attempt to break this circle of withholding service, the agency found and prepared 45 centers to accept physically handicapped children at the beginning of the demonstration phase of this project in September, 1965. In the event that there proved to be a significant correlation between the child's progress and the quality of service offered by the center which he attended, a CENTER RATING SCALE was devised which assessed a center on 25 items concerning its role in the community. (See Appendix, p. A-28.) Assessment was made by the

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*Center is used in this report as a general term indicating an organization which offers recreational services in a group setting and includes community center, group work agency, neighborhood house and settlement house.

Project Director together with the Placement Counselors.

The general areas included in the CENTER RATING SCALE were: philosophy, intake policy, attitude towards accepting handicapped children, facility in working with project personnel, readiness to carry on the integration program independently, and the general ability and attitude of the Executive Director.

Group Leader Evaluation.

This questionnaire (See Appendix, A-29) was introduced to the group leaders by the placement counselors after discussion with the supervisors at the centers. The form was filled in by the group leader and mailed to the agency or returned directly to the placement counselor.

The experience at the center being the major variable of the study, the group leader was asked to assess the study child's behavior in relation to others in the group. There were questions concerning the child's physical ability to participate in the group's activities, his relationship to the leader, his ability to make friends and how well he was accepted by the group.

Placement Counselor Observation.

This questionnaire was answered by the counselors after visits to the groups where there were handicapped children. It was not expected that this instrument would yield as much information as the one given to the group leaders, as they based their opinions on the winter's program with the child, whereas the counselor described the child in the group at the time of a particular visit. However, the counselor had seen the child in the home and sometimes at school before placement, and would therefore have the added advantage of being able to spot any change in behavior from that in a different setting. Further, the counselor could give added information about the relationship between the leader and the study child.

Sociometrics

It had been originally intended that a group of non-handicapped children would be studied in order to get their reaction towards association with handicapped children. Again, due to the cut in the budget, it was not possible to arrange staff time for this study. However, a small attempt was made on a one-shot basis to visit all of the groups where a handicapped child was placed and to get the entire group to make their choices of peers whom they would like to work with and play with.

The group leaders were given forms for all of the children in the group to use in listing their 5 choices for work and their 5 choices for play. When these forms were distributed, the leader was asked to read the following to the children:

> Now that you know most of the children in the group, I would like your help in finding out who you like to work and play with the most. You may choose any five children. It is all right to choose the same child twice if you would like to play as well as work with him (her). You may choose anyone in the group you wish to, including those children who are absent. This is not a test. Nobody in the group will see your answers. We may use your answers to form new groups next year.

It was hoped from this simple form to be able to assess the degree of acceptance or isolation experienced by the study child in the group and to see whether his preferences for his peers were reciprocated.

SUMMARY

The following is a list of the various forms that were used in the data collection and the times that they were given.

Participant	Instrument	Time
CHILD	Child Interview I*	Beginning of Demonstration
	" " II	End of 1st Year
	" " III	End of 2nd Year
PARENTS	Family Interview I*	Beginning of Demonstration
	" " II	End of 1st Year
	" " III	End of 2nd Year
TEACHER	Teacher Interview I*	Beginning of Demonstration
	" " II	End of 1st Year
	" " III	End of 2nd Year

FOR EXPERIENTAL GROUP ONLY:

DIRECTOR AND SUPERVISORS AT CENTER	Center Rating Scale	4 Times During the 2 Years
GROUP LEADER	Group Leader Evaluation I	End of 1st Year
	Group Leader Evaluation II	End of 2nd Year
PLACEMENT COUNSELOR	Placement Counselor Evaluation I	End of 1st Year
	Placement Counselor Evaluation II	Enf of 2nd Year
MEMBERS OF THE RECREATION CENTER GROUP	Sociometric	Near end of 2nd Year

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*A Change Scale combined the data from the child's parents' and teacher's interviews to give a single rating of the child's social functioning ability. (See Chapter V.)

CHAPTER V

ANALYSIS - FINDINGS

Data collection -- whether in research or practice -- is relatively easy compared with data analysis. It is true that it is necessary to anticipate that the data to be obtained are sufficient quantitatively and qualitatively to answer a study's major questions or test hyptheses; or in practice to be able to plan effectively. The problem is made more difficult when, as was the case in the present study - most of the data to be analyzed are interview responses, obtained from parents and children in three comprehensive depth interviews over a two-year period. The responses included the parents' attitude toward the handicapped child, their child-rearing practices; also, how they viewed the child's attitude toward his handicap, and the adjustment the family had made both to the child and societal attitudes toward orthopedically handicapped children. The most relevant data obtained from the study children were in what was described as the self-image interview, actually a major part of the child interview schedule.

The analysis was further complicated by the fact that in addition to the usual problems of getting at the meaning of the data, it was necessary to utilize these data as a means of evaluating the demonstration. This meant that the data from the first parent and child interviews had to be viewed as the status of parental child rearing practices before the demonstration; similarly, the data concerning the child's self-image in the first interview had to be considered the status of his self-image before the demonstration began. A basic assumption of this evaluation was that change in a child's social functioning, positive or negative, as well as his self-image, can generally be attributed to the influence of the home, and to a lesser degree, the school. Accordingly, the first interviews with the teachers of the study children, described in a later section of this chapter, also took place at the beginning of the demonstration. Obviously, this assumption would apply equally to the children in the Control as to those in the Experimental group. Any evidence of additional change in the Experimental group that was not attributable to the home or the school was interpreted as due to the rehabilitation variable, i.e., the center experience.

For the data to be used as bases for evaluation of the differences, if any, between the children in the Experimental group and those in the Control group, they needed to be summarized, classified and integrated in a specific way that at the same time did justice to what the writer had learned from the parents, and children on an impressionistic basis from familiarity with the interview responses. The process first described, or the conceptualization of the data, is essential irrespective of the data processing method used, i.e., whether by computer, or by keysort card as in the case of the present study. The writer prefers the latter method for research based on interview data. For one thing, the computer cannot advise you how to find a unifying frame of reference as a basis for conceptualization, though for making correlations, the computer is more efficient.

The frame of reference had, of course, to grow out of the study design and, in particular, out of familiarity with the responses through intensive examination of these in the interview schedules after coding. For our study, it was necessary to arrive at a conceptualization that would permit classification of responses in a way that would facilitate measurement of change, particularly, direction of change, in a family's attitude toward and handling of the study child, and the effect of the handicapped child on the family's life style. The interview schedules were the same for the Experimental and Control families, except for the addition of questions about the center experience for the Experimental group. In place of these questions the Control families were asked about growth experiences outside of home and school to which the study child might have been exposed. The core of this conceptualization was the assessment of a family's overall role vis a vis the handicapped child that could br rated as follows: facilitating; deterring; questionable, i.e., combining some of both the positive and negative ratings.

A similar conceptualization of the child's self-image data was essential in order to be able to rate a positive or negative direction of change.

For purposes of evaluation, two techniques evolved: the Comprehensive Family Rating, and the Self-Image Evaluation. In the preparation of this final report it became evident that these research techniques had wide applicability to the entire field of social work practice. Accordingly, it was decided to present the Comprehensive Family Rating[1] and the Self-Image Evaluation[2] in individual monographs where more background details and illustrative case material could be included. Although of value as separate monographs, a fuller appreciation of their use in both social work research and practice can be had by viewing the two together by means of which a deeper appreciation can be gained of the impact of the family and school as well as that of larger social milieu upon a family's child-rearing role and upon a child's self-image.

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[1] Celia S. Deschin. Families in Trouble: A Comprehensive Family Rating Techinque. Monograph II Mimeographed by New York Service for the Handicapped, September, 1970.

[2] Celia S. Deschin. They Can Communicate: Self-Image Evaluation. Monograph I Mimeographed by New York Service for the Handicapped, June, 1970.

THE COMPREHENSIVE FAMILY RATING

In assessing a family's overall role vis a vis the handicapped child as facilitating; deterring; or questionable; it was recognized that parents who play a facilitating role in enabling their handicapped child to move out to and utilize constructively a new experience involving activity with non-handicapped peers may also at times play a deterring role, and vice versa. The ratings were assigned on the basis of the family's customary role together with confirming data from the child's self-image and on the basis of each individual interview before being combined into a final rating, with the first interview, providing a before measure against which to mark any direction of change.

Accordingly, it was found that the responses from the three parent interviews could be categorized under the three components listed below:

The effect on the household of having a handicapped child
Parental child-rearing attitudes
Parental handling of the handicapped and his non-handicapped siblings

Although these techniques developed in research, they grew out of the writer"s extensive casework experience in both practice and teaching, as well as in research that involved casework interviewing and understanding of behavior undertaken while the writer was teaching and conducting research at the Adelphi University Graduate School of Social Work. An underlying assumption of the Comprehensive Family Rating is that individual responses to interview questions, even when repeated in successive interviews, provide only partial insight. These need to be combined with related responses and checked with responses of relevant family members. For example, describing a specific mother as "protective" of her physically handicapped child requires a variety of criteria other than the mother's responses and observation of her behavior. It requires: the reaction of the handicapped child to the handling; differentiation in the mother's rearing of the non-handicapped child; her goals and aspirations for the _non_-handicapped child compared with these for the handicapped child; and her awareness of the meaning of the handicap to the study child. It is also essential to know the following: the kind of person she is; her relationship with non-handicapped children along with her satisfaction and/or dissatisfactions with her role within the family. The Comprehensive Family Rating involved processing a mother's responses with respect to her handling and attitude toward the physically handicapped child, taking into consideration factors such as those mentioned above. The basic assumption here is that human beings function as an integral whole. If the many responses having to do with child-rearing are considered separately, even if some aspects of the behavior of parents are weighted more than others, there is likely to be some distortion in the interpretation. Various units of attitudes and behavior need to be synthesized to get a clear picture of the family's life style and the role of the handicapped child in it, and this was made possible with the Comprehensive Family Rating. The need to interpret a family as a whole as accurately as possible was the rationale for the conceptualization of this instrument.

These three components listed on p. 46 were considered to make up the impact on the child of the family's attitudes, child-rearing practices and family life style. Some of the components included comparisons between parental handling of the handicapped and non-handicapped siblings. Further, the focus was not limited to the status of the family at any given time, but took into account the direction of change over the two-year demonstration period from the baseline of the first interview to the third. The second or intermediate interview at the end of the first year of the demonstration was used as a barometer for analyzing home changes that might temporarily affect the self-image rating. For example, a father's desertion affected the self-image of one child in a marked downward trend which was reversed by the time of the interview a year later. Interpretation of any set of responses was made in reference to all the available data at the time, and was checked for internal consistency as well as relevance to the family's current social situation.

A discussion of the components, together with the questions that were included in each follows:

Effect on Household

In the conceptualization of the responses having to do with the effect on members of the household of having a handicapped child in the family, the following aspects of family life were taken into consideration:

a) The amount of time and attention the handicapped child required of the mother resulting from the handicap, over and above the ordinary needs of children.

b) The effect on siblings because of the child's handicap, apart from responsibility; for example, a child might have a younger sibling and indicate some resentment.

c) Similarly, the effect on the father and indications of resentment on his part.

d) Evidence that the child's handicap interfered with parents' social life.

e) Problems in handicapped child's education because of the handicap.

Sample questions in Interview I

Wha changes did this make in your life?

Does caring for *________ make problems for you in home? Yes ( ) No ( )
If "yes", what kind of problems?

a) How do the siblings feel about their sibling?

b) What does *________ do with the siblings?

In interview II and III, comparable questions were asked but put in the form of an opinion about any change in the above since the previous interview as follows:

> It has been said that having a handicapped child makes problems for the whole family. The following are some opinions that people have expressed regarding this. (Interviewer should ask for comments on changes since last interview. Record should show: Agree, Disagree, or No response, or include comments.)
>
> a) A handicapped child requires more attention and care than other children.

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* The name of the handicapped child.

b) A lot of time has to be spent going to doctors, clinics, hospitals, etc.

c) There are problems in finding a proper school.

d) Other children in the family resent special attention to handicapped child.

e) Husband resents additional responsibilities for handicapped child.

f) Other children object to having additional responsibilities because of handicapped child.

g) Mother has less time to care for other children.

h) Parents cannot have normal social life.

Parental Attitude

Conceptualization of responses having to do with parental attitudes were based on the following:

a) Parents' description of the study child.

b) Recognition of him as an individual.

c) The educational goals and work projected for the child.

d) Recognition of potential talents and/or skills, or a lack in parents' attitude toward the handicap, (i.e., acceptance, pity).

e) Parental awareness of the child's attitude toward the handicap and his use of the handicap (i.e., unusual efforts to overcome the effects of his handicap or exploitation of his handicap to get special benefits and/or attention.).

Interview questions related to the above were:

How does *_______ relate to his handicap?

Knocks himself out trying to prove he can do things he really can't do? Yes ( ) No ( )
Describe____________________

Can you think of times when you forgot *________was handicapped? Yes ( ) No ( )

Can you remember what *_______was doing at that time?

Handicapped children like normal children are all different and have different kinds of abilities.

- Have you noticed any special talents or capabilities in *______? Yes ( ) No ( )

  Can you tell me about this?

- What are your future plans for your children?
  Handicapped child?______________________
  Siblings?______________________

  For education______________________

  For work______________________

- What would you like your children to be when they grow up?

  Handicapped child?______________________

  Siblings?______________________

- If someone were to ask you to describe *__________ as a person, what would you say?

- How do you feel about *__________ as a person?

- What three words best describe *__________?

The above questions were asked again in Interview II at the end of the first year of the demonstration.

These questions were repeated in Interview III at the end of the second year.

Parental Handling

To conceptualize responses in this category, the following were taken into consideration:

a) The parental handling of the study child in relation to handling of siblings.

b) If only child, how much independence was permitted the handicapped child.

c) Strictness in watching over him.

d) Kind of discipline.

e) Delegation of chores.

f) Awareness of child's reaction to his handicaps.

The above considerations can be summed up in the question: Is the child permitted to develop within his capacities, or is his growth being hampered?

These are questions from the Family Interview:

- What kinds of chores do you give your other children?
- What kinds of responsibilities for the care of *________ do you give to the other children?
- What kinds of chores around the house do you give*________?
- When any of your children misbehave, how do you punish them?
- If *________ misbehaves, what is the punishment?
- Is your neighborhood one that is safe for children to play out of doors near your house?
  Yes ( ) No ( ) Reasons:____________________
- Suppose *________ is playing out of doors, would you:
  1. Make him stay in own area where you can watch him?
     Yes ( ) No ( ) Reasons:____________
  2. Let him go to a playground alone?
     Yes ( ) No ( ) Reasons________________
  3. Let him go away from neighborhood only if with another child? Yes ( ) No ( ) Reasons:________
- How does *________ react to his handicap?

  Forgets it when he is doing things he enjoys?
  Yes ( ) No ( ) Desceibe__________________
- Parents should be less strict with their handicapped child than with other children.

  Agree_____ Disagree________ Comment:_____________

The assessment of each of the above components was summarized by checking one of the following evaluatory statements in each category.

Effect on Household

- Family has adjusted to the child's handicap.
- Handicap has created some problems and/or some resentment.
- Handicap is a great burden on the family and/or has created many problems.

Parental Attitudes

- Parent individualizes child positively.
- Parent generalizes child's abilities and attitudes.
- Parent minimizes or does not recognize abilities or talents.
- Parent individualizes child negatively.

Parental Handling

- Handling highly facilitating.
- Handling indicates facilitation in some areas; over-protectiveness in others.

Highly or moderately over-protective, or rejection received the same score and the parental handling would be evaluated as deterring.

In summary, the three components: Effect on Household of handicapped child, Parental Attitude, and Parental Handling were each rated as High, Medium or Low in the initial interview and for each sucessive interview, thus giving a record of the direction of change for each component.

On the basis for scores assigned to each of the three components, a comprehensive score was obtained that appraised the family's child-rearing functioning so that it was possible to indicate that a given Comprehensive Family Rating was High, Medium or Low for each of the three interviews. Further, having the Comprehensive Family Rating for each interview permitted the final assessment of the direction of change, positive or negative. Table III shows that 83.5 percent of the Experimental group had facilitating homes as against 71.4 percent of the Control group. For those 36 Experimental children who remained in the program only one year, 75 percent had facilitating homes, slightly higher than in the Control group.

TABLE III

COMPARISON OF COMPREHENSIVE FAMILY RATINGS OF THE EXPERIMENTAL AND CONTROL GROUPS

	2-Year Experimental (N=79)		Active Control (=42)		1-Year Experimental (N=36)	
	No.	Percent	No.	Percent	No.	Percent
Family Rating						
Remained High	31	39.2	12	28.6	18	50.0
Remained Medium	19	24.0	9	21.4	8	22.2
Remained Low	1	1.3	3	4.8	3	8.3
Remained the same		64.5		54.8		80.5
Improved	16	20.3	9	21.4	1	2.8
Regressed	12	15.2	10	23.8	6	16.7
Facilitating:						
Remained High) Remained Medium)--- Improved)		83.5		71.4		75.0
Deterring:						
Remained Low) Regressed)---		16.5		28.6		25.0

SELF-IMAGE EVALUATION

It is significant that, in the one-time use of the Self-Image Instrument with both non-handicapped and handicapped children as described in Monograph I, as well as in the three-time use in this demonstration, the most meaningful and reliable insight into the child's self-image was provided by the same questions. This will become clear in the illustrations that follow. Pertinent here is the fact that the sentence-completion portion of the instrument, requiring as it did that the child project himself into a series of situations having relevance for his life experiences, reflected most graphically and reliably the child's reality; his concerns as well as his satisfactions; problems as well as achievement, including in some instances, problem areas not clearly discernible from the rest of the self-image data.

Responses to direct self-image questions such as "What two things do you like most about yourself? ... least? ...." were also highly revealing. These particular questions were troubling to a number of the children, notably to those whose self-image was largely negative, or contained aspects that were positive and others that were negative. It is, therefore, not surprising that these questions, introduced in the second Self-Image Interview, elicited the largest proportion of "don't know", or inappropriate responses.

This is not to imply that the other questions in the Self-Image interview were not of importance. It is to imply that in some of the other questions, e.g., choice of vocational goals, identification with adults and aspirations were more likely to be changeable, and to change in response to immediate events that might or might not be included in the family background material. These andother aspects of the Self-Image Instrument are described and illustrated in the section that follows.

Parents had been informed that we would be talking with their handicapped child alone since we wanted to learn how the child viewed himself. However, it was left up to parents whether they or the child were interviewed first. Generally, parents were seen first. Interviewers noted and observed parental attitudes while the child was being interviewed -- specifically, whether they permitted the child to answer for himself. This was taken into consideration in the analysis of the data. Even if the interviewers had not noted parental attitudes,* this could usually be inferred from a comparison between parent and child responses. A good illustration of this is the question as to whether the child ever forgets his handicap, as noted by the mother and the handicapped child. More difficult to discern is a covert attitude on the part of mothers who pretend, as it were, that the child does not have a handicap and keep overt awareness of the handicap from the child and his siblings.

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*The last page of each interview with the family included the following: evaluation of physical condition of the home, atmosphere of the home, interaction between child and siblings, and also, with parents; conditions under which the interview took place; impressions of parents: their interest in the interview and comprehension of questions; together with other details about parents, their physical condition, and relevant comments. In the child's interview, observations of the parent interaction and impressions as to whether child looked for assistance from parents were included.

Illustrations from the Children's Integration Study of Responses to the Self-Image Instrument.

In the monograph on the Self-Image Instrument, the full responses of 10 children are given. They include black, white and Puerto Rican children from low and middle socio-economic groups, and from the youngest age bracket, 6 to 8 years old, the middle group, 8 to 10, and the oldest age group, 11 to 13 years old.

In this Final Report, the responses of three of these children are given. In looking for the direction of the child's self-assessment, it is useful to follow the responses to each question horizontally, thus tracing the progress either positive or negative from Interview I to Interview III.

Only minimal family history is needed for each illustration in order to enable the reader to appreciate fully how the responses of the child can provide insight into his life situation: his relationship to siblings, peers, parents and teachers; along with satisfactions, dissatisfactions and/or problems in these areas.

It will be recalled that Interview I with both parents and children took place in the home before the study population had been divided into Experimental and Control groups. The Self-Image questions listed below were a part of the research interviews with the child, and were identical for children in both groups. The interview began with a few questions about school, friends, and what they would like "to do right now."

There were some differences in the introductory questions in Interview II and III: for the Experimental group, these included the child's reactions to the center experience; for the Control, these included questions about any extra-familial or group experiences. The introductory questions served to direct the child's attention to thinking about himself, as well as to give the child time to establish a positive rapport with the interviewer. (See page 59 for SELF-IMAGE INSTRUMENT)

Experimental 124

This is an 11 year old of mixed ethnic background with a diagnosis of post-polio. He wears leg braces and has a noticeable limp; his degree of disability was rated "mild". He attends a health class.*

He had been in and out of a rehabilitation center in the West Indies until age 7 when the family moved to New York for better medical care for him. At the time of the study demonstration, he was an out-patient at a City rehabilitation center.

This boy is the middle child of three and is assigned his share of household chores. Both parents work, father as a plasterer; mother as a typist, and the family is financially independent.

The reader will observe the frequency with which the child's responses include reference to his handicap despite the fact that no question in the Instrument asks about the handicap. What at first glance may appear to be preoccupation with the handicap, is on closer examination a growing boy's realistic reflection of societal attitudes towards a physical handicap. If references to his handicap are separated from the rest of his responses, no one could fail to be impressed with the normalcy of those other

(cont'd p.60)

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*This is a class for handicapped children, not all of whom are physically handicapped, in the regular school system.

Case Number: Experimental 124 Control_____

QUESTIONS	Interview I	Interview II	Interview III
If you had three wishes, what would you wish for?	That I could walk. That I could go to college. Could play baseball.	My foot to get better. That I get promoted. That I get a good education.	My leg is better. Get a good education. Have a lot of money.
Who would you most want to be like?	Hercules A gladiator	Baseball player Don't know	Willie Mays Bob Hayes (football)
What would you most like to be when you grow up?	An artist	(not asked)	Maybe an architect
What 2 things do you like most about yourself?	(not asked)	I'm very active I don't cheat	I'm smart I don't have a bad temper about my foot
What 2 things do you like least about yourself?	(not asked)	Don't know	That I don't know how to do algebra
How far would you like to go in school? Why?	Until I get a job because you get a better education	To college. On TV it says college education - better job	(not asked)

SENTENCE COMPLETION	Interview I	Interview II	Interview III
a. Most of all, I want to ---	walk again	have a good education	have a good education
b. I would like to forget the time I--	missed a home run	couldn't play tag - couldn't run	Failed on math test
c. If people would only ---	forget I have polio	stop asking me questions about my foot	stop fighting
d. I know I could do anything if--	if I didn't have polio	if I didn't have a bad leg	my leg was better
e. I could be happy if---	I could walk like any other person	my leg would only get better	my leg was better
f. Other school children---	always try to help me	do not have a bad leg	are very nice
g. People who have trouble walking--	would like to walk again	is very sad thing. They don't have chance to do things	sometimes get mad with themselves
h. If I weren't held back by---	that boy, I would have punched the boy in the nose	my leg, could do many things	my handicap
i. I am worried about---	improving my English	my leg because it seems it never will get better	my future education
j. No matter how hard I try, I---	would like to be like others	still can't do things other children do	I can't swim so good
k. I like to be treated---	like a normal child	just like the other children	as if nothing was wrong with

SELF-IMAGE INSTRUMENT

1. If you had three wishes, what would you wish for?

2. Who would you most like to be like?
First Choice______________Second Choice______________

3. What would you most like to be when you grow up?______________

4. a) What two things do you like most about yourself?__________
b) What two things do you like least about yourself?__________

5. How far would you like to go in school?_________Why?__________

6. (The projective sentence-completion question was adapted by the writer from Cruickshank for this population. The numbers following the letters on each question are those found in the Cruickshank instrument.[3] This question was given in all three interviews.) We want you to finish these sentences in your own words:

a. (1) Most of all, I want to______________
b. (3) I would like to forget the time I______________
c. (6) If people would only______________
d. (7) I know I could do anything if______________
e. (11) I could be happy if ______________
f. (21) Other school children______________
g. (23) People who have trouble walking______________
h. (26) If I weren't held back by______________
i. (29) I am worried about______________
j. (30) No matter how hard I try, I______________
k. (31) I like to be treated______________

7. I have asked you a lot of questions -- what would you like to ask me?______________

____

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[3] Taken from Cruickshank, William M. (Ed.), Psychology of Exceptional Children and Youth. (Cruickshank's Chapter 6: Psychological Considerations with Crippled Children. Questions Nos. 28, 19, and 24 of the Projective Sentence-Completion test, pp. 328-329). Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1963.

responses.

Is not the inclusion of the reference to the handicapping condition a normal response to the prejudicial societal attitude rather than unrealistic preoccupation of the boy? For an example of this see "c" and "k" of the sentence-completion question in the three interviews.

His responses reflect a high degree of perceptiveness and aspiration.

The Self-Image was rated as positive with improvement in Interview III. The family was rated as highly facilitating in Interview I but became less facilitating to the child by Interview III. The improvement in Self-Image rating is all the more significant since, as was seen in the analysis of a number of children in this age group, the concerns about the handicapping condition become more pressing as they approach adolescence.

Clues to the boy's improved self-image in Interview III are found in the evaluations of the boy's experiences at the Community Center and at school. In the former, he was praised for his friendly, outgoing, kind attitude and for his lack of self-consciousness about his handicap. He almost never missed a session at the Community Center, was active and "well adjusted." He was the only handicapped child in the group and had an easy-going relationship with non-handicapped youngsters who were helpful to him. He was able to continue his interest in sports with other boys running for him when this was necessary.

At school, while he was nominally in a Health Class, it served as a home room for variety of different types of handicapped children. From there he attended regular classes in his subjects.

It was a new and attractive school that was "departmentalized." His teachers described him as having a "marvelous personality." adding that he could be in a regular class. He was considered independent, self-reliant, superior academically, and was elected President of his class.

Despite this, he was thought to resent being in a Health Class and did not always hide his resentment, sometimes not working up to his potential. He was described by one teacher as follows: "His hand was always up first when questions were asked," but the three school reports make clear that he lacked stimulation.

It is, accordingly, to be hoped that his future teachers continue to recognize and support his interest, desire, and ability to profit from higher education. Were this a practice case, the child's reponses, in particular in the direct self-image question in Interview II - (What 2 things do you like most about yourself? ..... least?) and III, his expressed interest in a college education in response to the education question in Interview I and II and in "a" of the sentence-completion portion in Interview II and III -- all of these would indicate where he needs support.

Control 317

This is an 8 year-old Puerto Rican girl with a diagnosis of Cerebral Palsy. She walks with a severe limp and her disability is rated as "moderate" and she attends a Health Class.

She is the middle child of five children. Father is a machine operator with low-income. Mother reports that she forgets that girl is handicapped and believes that the child also forgets!

The child's version is that she "can never forget" that she is handicapped.

She omits answering many questions in the Self-Image Instrument in the first interview, particularly in the projective sentence-completion part, though she answered all but one question in Interview II and all of the questions in Interview III.

Analysis of her responses suggests that she is concerned with lack of privacy at home and the population explosion in the family. This is reflected indirectly in the lack of privacy in Interview III (three wishes) and in Interview II in the fourth wish she adds: "No more babies."

Her response to the question about education suggests an unusually negative relationship to school that would need to be examined as a problem area if the family and child came to the attention of a social agency.

Another response -- this one in the sentence-completion part of the instrument -- that is atypical and indicative of possible problem area in accepting discipline and limits is in Interview II. "I like to be treated my way," and her earlier response in this interview "Please, no high school." This is confirmed in part by clues to a poor relationship with her mother and to teachers in school.

This girl tells you where her problem areas are in Interview II in sentence-completion -- "I am worried about school and my mother." Her identification with adults is questionable, though she mentions adults, this is not confirmed in other responses. Her wanting to be a teacher seems unrealistic in view of her attitude about school. See sentence-completion, Interview

Case Number: Experimental______ Control 317

QUESTIONS	Interview I	Interview II	Interview III
If you had three wishes, what would you wish for?	typewriter; to be a therapist to teach children; pizzas	box of crayons sun glasses; had my own house; no more babies	typewriter; my own room and closet. I don't like anyone wearing my clothes
Who would you most want to be like?	My aunt Anna my mother	my mother; my father	teacher
What would you most like to be when you grow up?	a teacher a mother	(not asked)	Santa Claus Dick VanDyke (much laughter)
What 2 things do you like most about yourself?	(not asked)	I don't know	can't think of anything
What 2 things do you like least about yourself?	(not asked)	I don't know	my clothes
How far would you like to go in school? Why?	I don't know	I don't know - please, no high school	(not asked)
SENTENCE COMPLETION	Interview I	Interview II	Interview III
a. Most of all, I want to ---	be a typist	be a camper	play
b. I would like to forget the time I--	No reply	bad	went to school
c. If people would only ---	No reply	No reply	watch out
d. I know I could do anything if--	No reply	I like	wasn't like this
e. I could be happy if---	I had no braces on	I want	I'm not like this
f. Other school children---	go to school	like to work, paint	play with me
g. People who have trouble walking--	put braces on	have to go in wheelchair	can't jump
h. If I weren't held back by---	no reply	the teacher	my father
i. I am worried about---	I'm crippled	the school and my mother	my clothes when they shrink
j. No matter how hard I try, I---	No reply	can do better than that	can walk
k. I like to be treated---	nice	my way	like a girl

III. Her self-image was rated as ambivalent, i.e., containing some positive and some negative aspects with the third self-image responses suggesting more negative than in the first two.

What the Self-Image data suggest is that she has little confidence in adults, confirmed by the superficial level of her communication. It would be important to help her to gain confidence sufficient to feel free to communicate on a deeper level.

Her problems seem to be of long standing for prior to the beginning of the Children's Integration Study in 1965, she had attended a segregated recreation camp and it was reported that she preferred to play by herself and did not readily participate in activities with other children. Her teachers noted that she was a "follower" with respect to her classmates. All the adults who have had contact with her refer to her "hot temper". It is likely she had considerable anxiety that is manifested by her struggles to have "her way", or go it alone.

It is significant that three of her siblings were interviewed in the student thesis concerning the non-handicapped siblings of the Integration Study's handicapped children.[4] All three were rated as having a positive self-image.

This raises the question as to the reality of the mother's belief that the girl forgets she has a handicap. It also means that the mother can ignore the effect of the handicap on the child's self-image. In a practice situation, it would be important to help the child gain self-confidence. Beginning contact with the mother could be developed after more meaningful communication has been initiated in those areas in which she was unable to respond.

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[4] Celia S. Deschin. They *Can* Communicate: Self-Image Evaluation. Monograph I - Mimeographed by New York Service for the Handicapped, June, 1970, p. 25.

Experimental 158

This is a 7 year-old white boy with a diagnosis of multiple congenital anomalies and club foot. He has fair ability in walking; the disability was rated "mild". He attends a regular class.

This boy is the youngest of three children. The family has middle-class status.

At the time of this first interview his self-image was rated positive, though not at the highest level. The only clue to a possible area of concern is the absence of identification with a member of his family in view of the fact that his other responses were not atypical of a child of his age and social status -- either positive or negative.

In the second interview, his only wish is: "to be a big boy." His identification is with one of his brothers. His responses to the question: What two things do you like most ... least... about yourself, are of interest -- the first is inappropriate -- and he does not answer to the second part.

In the third interview his one wish is to have more friends. He wants to be a teacher when he grows up. BUT -- the next three questions are not answered at all. This lack of response was invariably an indication of conern and stress in some area. This is also reflected in the sentence-completion question: I would like to forget the time I "was born". Also, atypical and indicative of ambivalence about growing up is: I could be happy if "I was young". Another item was: I am worried about "other people who die".

Case Number: Experimental 158 Control_____

QUESTIONS	Interview I	Interview II	Interview III
If you had three wishes, what would you wish for?	train set Monopoly Do homework, go to park	Be a big boy	have eore friends
Who would you most want to be like?	Fernando (best friend) Brothers	My brothers	No reply
What would you most like to be when you grow up?	Fireman Doctor	(not asked)	teacher
What 2 things do you like most about yourself?	(not asked)	Playing after school	No reply
What 2 things do you like least about yourself?	(not asked)	No reply	No reply
How far would you like to go in school? Why?	College, learn a lot	Finish college	
SENTENCE COMPLETION	**Interview I**	**Interview II**	**Interview III**
a. Most of all, I want to ---	play games	fireman	be a teacher
b. I would like to forget the time I--	nighttime	was small	born
c. If people would only ---	like to go to the store	be kind	be kind
d. I know I could do anything if--	I went to play in the park	I was good	it was easy
e. I could be happy if---	I play	I was good in school	I was young
f. Other school children---	like to read	are happy	like me
g. People who have trouble walking--	go to the hospital	are sad	need a walking stick
h. If I weren't held back by---	my jacket	my brother	the teacher
i. I am worried about---	sleeping	me	other people who die
j. No matter how hard I try, I---	I "rite"	work	would be good
k. I like to be treated---	candy	a big boy	nice

This is one of the few children in the Children's Integration Study whose self-image dropped from a positive rating to the lowest rating. The boy provides highly significant information about his concerns that would make it possible to initiate discussion with the family before a crisis develops.

It was found that even a few excerpts from a child's self-image responses were sufficiently significant to point up the kind of insight that even young children can provide under the stimulus of meaningful communication. In this study, the insight was into the world of the physically handicapped, frequently compounded by minority group problems and low socio-economic status along with other social handicaps. The following illustration shows the need for awareness of what life is like in the urban ghetto for a black child who is physically handicapped.

This is a 10 year-old black boy who does not fit the stereotype. His diagnosis is post-polio (from age 7). His left leg is affected, and the disability was rated "mild". He is in regular class at school.

At the beginning of the Integration Study he was living with his parents and a younger brother in a two-room apartment with all members of the family sleeping in the living room. Since the father was unemployed, the family were receiving public assistance. By the end of the first year, the father had left the home. The family was facilitating. The boy's self-image began on a positive level, went down slightly after his father left home and went up to the original positive level in the third interview. Although the boy's self-image responses did not reflect identification with either parent, his vocational identification is: engineer, teacher, and social worker and in the third interview, he wants to be like a man who is a neighbor.

Relevant responses from the Sentence-Completion series are:

Interview I: I could be happy "if somebody makes jobs".

After all, he lost his father primarily because the latter could not find work. In Interview II, he said he wants to be "a workman" indicating some identification with his father. In all three interviews, his responses reflect the atmosphere and pressures of ghetto life in New York.

Interview I: If I weren't held back by "them big kids".

Interview II: He likes most about himself that "I'm nice; and I never like to start fights".

He does not say what he likes least about himself though his self-image improved and was rated positive.

Interview III: If people would only "stop killing and robbing."

If I weren't held back by "fighting".

I am worried "when I have to start fighting."

This boy is described by the community center's personnel as "creative, enthusiastic, cooperative, but confused at times, and relating well to both handicapped and non-handicapped children." He was average in school, somewhat shy, get along well with peers and teacher.

Without awareness of what it is like for a physically handicapped boy to live in New York City's ghetto, especially if he is not interested in violence or anti-social behavior, a middle-class social worker, psychiatrically oriented, might interpret this boy's responses as evidence of psychological problems, some having to do with idenfication with his sex, rather than a reaction to his environment.*

In both the Experimental and the Control groups, the majority of the children had self-images that remained positive or improved. For those who were evaluated,** the following Table shows the comparison of the two groups.

TABLE IV

COMPARISON OF RESULTS OF SELF-IMAGE EVALUATION FOR EXPERIMENTAL AND CONTROL GROUPS

	SELF-IMAGE RATING					
	Improved		Remained Positive		Negative or Regressed	
	No.	Percent	No.	Percent	No.	Percent
Experimental Active (79)	36	45.6	36	45.6	7	8.8
Control Active (42)	15	35.7	20	47.6	7	16.7
Experimental Withdrawal (36) (after 1 yr.)	19	52.8	17	47.2	0	-

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*American culture still accepts a concept of maleness as needing to "fight it out" and be "tough" rather than "gentle." In 1962, the writer had occasion to talk successively to five high school junior and senior classes on problems of identification, in particular in the area of sex and identification with adults. I mentioned the need to begin thinking of a change in the rearing of boys since war as a solution to national and international problems sooner or later, had to be outlawed in a world of civilized nations. The youngsters picked this up enthusiastically but the teachers -- especially the men -- had many reservations. After all, we have always had sensitive male artists, writers and poets who did not fit the still prevailing cultural stereotypes about boys and their rearing, particular among blacks and Puerto Ricans.

**See p. 80 for an explanation of the "active" figures used in Table IV.

It can be seen from Table IV that even those children who withdrew from the center programs after one year showed more improvement and less regression in this rating than did the children in the Control group.

TEACHER'S EVALUATION

The interviews for the Teacher's Evaluation were all made by the same research staff who conducted the family and child interviews and, wherever possible, the same interviewer returned to the same school. The conditions under which the interviews took place reflected problems and differences in the New York City public school system. There were differences in the atmosphere -- physical and psychological -- in the schools; differences in the teachers' training and experience; differences in the interest of the teachers in participating in the study* and in teaching handicapped children. Health Classes usually included children with a variety of handicaps. They are also likely to include several grades in one class. Where teacher preparation was inadequate, and there was a lack of interest, the handicapped children were not often individualized or stimulated to fulfill their potential. This is borne out by the fact that we found the area of "teacher's relationship to the study child" the least well answered of the three aspects investigated, and hence it was the least productive area in the analysis of the teacher interview.

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*Arranging for the interviews with the individual teachers to fit their schedules and enlisting their participation in the study was a difficult and complex task as it would be in any large urban center where centralization was the administrative principle. A beginning in decentralization in the schools occurred after the data had been collected.

The interviewers reported that they were concerned about evidence of isolation and segregation of physically handicapped children from contact with their non-handicapped peers at the school. What seemed to be common to almost all of the schools was that practically nothing had been done to integrate physically handicapped children (whose intelligence may have been as high as or superior to the non-handicapped) into the regular classes. The handicapped use a different entrance, generally a side entrance, and are stared at by the other children. Classrooms are frequently in the basement, and off to the side. The reason given administratively is that this (e.g., classes in the basement) makes for easy entrance since a number of the children are in wheelchairs. The only opportunity for contact with the non-handicapped school population seems to have been during weekly assembly and sometimes in the lunchroom. However, in some schools, the handicapped eat earlier than the others. But even where there is some common participation at assembly or lunch, children in Health Classes sit by themselves. As one of the research interviewers put it: "The Health Class unit is so separated an entity that the handicapped might as well constitute a school of their own;" to which she added:

> In a number of instances, mildly handicapped children in regular classes were forbidden by the principal to participate in fire drills. A teacher asked her, "What is the child to do in the event of a fire -- stay and suffer possible burns?"

The above conditions were found to a large extent even in the newer schools.

There were principals, however, who made use of an integrative technique of assigning handicapped and non-handicapped children to the same home room. There were also some principals who had arranged for Health Classes to be included in the general school program. In such a school Health Classes were part of all activities, even outings and trips. These principals were in contrast to those who told the mother of one of our study children that he maintained Health Classes "only because it satisfied the requirement for 'integration.' Otherwise, Negro children would have been bussed in from another area." He was unwittingly confirming the high proportion of minority group children among the handicapped, suggesting that this may well be a factor in the failure to make possible even minimal integration in so many of the schools.

Teachers had little difficulty in describing and documenting the children's academic functioning but were less able to assess this potential. Also, they seem to have more difficulty, as implied earlier, in describing their relationship to the child. Whether these are due to the fact that they had not received sufficient training to individualize children, or whether this would have meant providing for each child a variety of tasks not available to teachers in order to assess a wide range of the child's potential, is not clear. It should be pointed out that some teachers had known the study child for several years prior to our first interview, while others had known the child for only a few months. Obviously, this made a difference in the teacher's individualization of any given child. For example, in the case of a girl described as "one of the oddest looking and oddest acting children" when the teacher first had the child in her class, this teacher noted three years later that "a lot of the strangeness has disappeared; she has become more sociable." Asked how she could account for this, the teacher replied, "New situations frighten her and it takes a long time for her to adjust." While this teacher was able to describe in detail her handling of the child with respect to the latter's academic work, she was much less able to assess the child's potential.

Teachers varied as to whether they knew about the children's outside interests, e.g., in the case of the study children in the experimental group, whether they knew about the child's experiences in the Center. Actually, all the teachers knew intellectually but not all made use of the knowledge. When they knew, it meant a great deal to the children to have opportunities in class to talk about their activities and achievements at the Centers. In this way, we learned how the children responded and used the experience, in particular, in a completely disinterested way.

The length of time a teacher knew a child obviously made a difference in her responses to the interview. Similarly, there were differences difficult to explain when there was a change in teachers. For example, it was puzzling when a teacher in one situation described a young boy as "well adjusted, sweet and likeable," who gets along with other children and was accepted by the other children "as one of the gang", and the following year a new teacher finds the same boy "very stubborn, emotional and immature." In such instances, the interviewer's observations and impressions together with later reports from a third teacher were helpful since the analysis of these interviews did not begin until all three reports were in. In the case of an 11 year-old Puerto Rican girl in a family where the paternity varied with the six children, including the study child, the first two reports from two different teachers varied greatly. Although the description of the child's academic abilities were comparable, the second teacher had much more understanding of the child. The first teacher was described by the interviewer as "opinionated, and somewhat rigid, with a notation that "her objectivity is questionable." The second teacher before her first year with this class had ended had been able to see the mother several times, finding her "very interested." (This was confirmed by our knowledge of the mother.)

Moreover, the second teacher, although aware of the child's problems in her academic functioning, showed greater understanding and helped the child to achieve better relationships with her classmates as well as to improve her class work.

In some instances the teacher's influence, positive or negative, was sufficiently strong to be interpreted as responsible for a change in a child's social functioning in school or in his self-image, or both. A case in point concerns a 9 year-old boy who had been living in a foster home since he was 2½, having been abandoned by his parents at birth. The baseline self-image was in the highest range and remained there until the third interview when there was a change in a negative direction. The Comprehensive Family Rating was evaluated as medium initially and remained at that level throughout, with no clues as to any change. The agency's placement counselor and the group leaders (the boy had two in the first year) described the boy's functioning in all areas as extremely high. The former described him as "eager and enthusiastic; very capable and friendly, well adjusted, and well liked.

It seemed important to look to the child's school functioning for a possible explanation. It is significant that his first teacher should have described him in terms similar to the group leaders: "extremely bright, a leader with a wonderful personality who accepts his deformity and disability with complete lack of self-consciousness. The child was enthusiastic about the center, enjoyed his activities -- woodworking, bowling and other games; liked the leaders and the children; talked about them at home and in school. His foster mother reported that the boy had benefited by the center experience.

This teacher felt that the child should not be in a health class "as it was not sufficiently stimulating to him." He was alraady attending a regular class for Social Studies. He was transferred to a regular class for the rest of his studies in the second year and had two teachers, both of them new: one a homeroom teacher; the other, a class teacher. The former was "very positive in her evaluation of the boy's abilities and personality and felt that he definitely belonged in a regular class. The latter, who was described by the interviewer as "resentful, impatient with, and lacking in understanding of the boy", felt that he was "troublesome, was not working and was taking advantage of his handicap." She said he was failing in several subjects because of his poor work habits and could not keep up with a regular class; that he should be in a health class.

The homeroom teacher, who had a social work background, was described as "establishing good rapport with the children, individualizing them and maintaining normal expectations of them. She was highly interested in the study child, felt that "his interest in science had been stimulated, specifically electronics; also that this had given him self-assurance and had generally enriched him." The interviewer noted that the class teacher, on the other hand, was indifferent to the demonstration and was outwardly hostile to the boy. The widely differing opinions of these two teachers regarding the child's academic ability and motivation provide a graphic illustration of the detrimental influence of a teacher's attitude on a child's learning. Whether the teacher's description of the boy's behavior is accurate is immaterial. The important thing is that there is reason to believe that the change in the child's Self-Image in a negative direction may well reflect his response to the classroom teacher.

In the absence of any serious change of a negative nature in other areas of the boy's life situation, it seems logical to infer that the classroom teacher's influence was probably responsible for the beginning downward trend in the child's Self-Image. This suggests the usefulness of examining children's self-image when significant changes occur to assess their impact before negative influences become more harmful to the child's functioning.

TABLE V (next page) shows the division of the Experimental and Control groups according to the academic evaluation made by the teachers. The plus or minus rating indicates the subsequent direction of change over the two years after the first baseline interview.

It is interesting to note that more children in the Experimental group improved academically than in the Control group, in spite of the fact that there were more middle-class homes amongst the Control group, which fact might have been expected to influence the stimulating expectations of that group and the teaching standards in the schools.

TABLE V

ACADEMIC EVALUATION

	RATING			
	"+"		"-"	
	No.	Percent	No.	Percent
Experimental (79)	54	68.4	25	31.6
Control (42)	21	50.0	21	50.0

Summary of the Significance of the Findings from the Teacher Interviews

In addition to the findings already presented regarding the conditions under which a majority of the physically handicapped children in our study were being educated, the following are of equal -- if not greater significance. These findings are, for the most part, taken directly from the observations of the interviewers, who were aware that the school staff feared accidents, and presumably being held responsible for accidents, particularly when an orthopedically handicapped child was being considered for transfer to a regular class. One of the study children was transported some distance to a health class. Our interviewer reported that the mother of this very bright child appealed to the principal of a school across the street from her home for transfer of her child to a regular class in this school for which he was qualified intellectually, according to his teacher.

The mother even offered to bring the child to school five minutes earlier and pick him up five minutes earlier. The principal refused on the grounds that there were "special Health classes for handicapped children."

> The fear of accidents seems out of proportion to the real danger inasmuch the children in the experimental group in our study were transported to and from 45 different centers without a single accident during the two years of the demonstration.
>
> Whatever the arrangements for Health classes, it would appear that these are based on an accomodation of the physical limitations of mobility of the handicapped children. Their intellectual needs seem not to be given special consideration. Some of the teachers made comments to the interviewers as follows: 'The child suffering from post-polio or comparable handicaps that do not affect intellectual functioning should not be placed with children whose handicaps are accompanied by some intellectual impairment.'[5]

The Quality of Education in Health Classes.

The interviewers were in general agreement that as a rule, in the schools included in our study, the quality of education in Health Classes seemed to leave much to be desired. "One interviewer described the situation as follows:

> Generally, I found the quality of education in health classes of substandard level. First, the different grades in one class made it very difficult for the teacher to be appropriately prepared for each grade and give sufficient time to each grade. Very often, the expectations for these classes are low with the result that the

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[5] Deschin, Celia S. Implications for Schools of a Demonstration Project to Integrate Orthopedically Handicapped Children in Community Centers with their Non-Handicapped Peers. Paper presented at the Scientific Forum of the Research Council of the American School Health Association, Miami Beach, Florida, October 21, 1967, p. 11. (The paper was based on a detailed analysis of a random sample of 60 children from the study population.)

> children fall behind and there is less and less challenge and stimulation.

"Another interviewer, one who was involved in a majority of the interviewers with parents, children, as well as with teachers, made the following observation:

> The general tempo of the health classes is considerably slower than that of regular classes. As a result, the brighter handicapped child is at a disadvantage. The slower child, however, does receive much more individualized attention since the classes are small, approximately 10-12.

> In congested slum areas where the schooling is extremely poor, handicapped children as well as the non-handicapped in regular classes often receive little education. In one such class, teachers in these schools often indicate that all they are able to do is to try to maintain a semblance of order. They make little attempt to teach. Under such circumstances, the small Health class provides some opportunity for children to learn.

"She added this discerning comment regarding the qualifications of teacher in health classes:

> The teachers of health classes are unevenly qualified in terms of educational background. Their attitudes vary from indifference, oversolicitude and lack of awareness of the individual child to a vital interest, concern and knowledge as to how to meet the needs of the child who has a handicap.

"Just how much authority the principal has is not clear. Apparently, however, his own attitude and imagination, as well as his interest in the welfare and education of handicapped children are significant factors affecting the degree of segregation and the standard of education they are likely to receive."[6]

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[6] Ibid., p.12.

This is confirmed by what teachers and the mothers of our study children told us. For example, it was reported that because of a shortage of teachers, many new, young and inexperienced teachers without special education, as well as teachers who have been out of the system for a long time, are assigned to Health classes, because it is thought that they cannot handle a regular class. We learned from some mothers that "once the teachers gain experience and improve in the Health classes, they are sent 'upstairs' to the regular classes."

Teachers' Attitude[7]

> A number of health class teachers were asked about their motivation in becoming teachers of handicapped children. Some had simply been assigned to a health class instead of a regular class, felt challenged and stayed on. Others had had other careers previously which motivated them toward health classes, such as dental hygienists, physiotherapists, occupational therapists and medical social workers. A few teachers had physical handicaps themselves or had children of their own with handicaps. From the responses of individual teachers to questions relating to their qualifications to teach in health classes, it would appear that few have special licenses, although a number indicated interest in learning more about children who are placed in health classes and some were taking special courses.
>
> Those who were interviewed appear to reflect a good cross section of the teacher population. they ranged from bright, enthusiastic teachers to those whose teaching had become routine and unimaginative; from young, inexperienced teachers to those with more than 25 years of teaching experience. A few demonstrated a knowledge of the psychological implications of handicapping and the meaning of the child's behavior in relation to his handicap. Others showed little or no such understanding. Teachers exhibited varying degrees of sensitivity toward the handicapped child, such as pity, ideas that the

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[7] *Ibid.*, p. 17-18

> handicapped child is "inferior" to the non-handicapped, acceptance, and high realistic expectations. A few of the teachers felt strongly about integrating handicapped children with non-handicapped in regular classes and felt challenged in trying to help the children achieve transfer to regular classes. That integrated classes are likely to provide more stimulus and increased educational opportunity for handicapped children seems likely from the findings of our study.

THE WITHDRAWALS

Before turning to discussion of the findings from data collection related to the center experience, mention should be made here about the families and children who did not continue until the end of the demonstration period. When it became apparent that there was an appreciable number of families who had moved or had withdrawn their child from the demonstration for medical and other reasons, the research director took responsibility for including a detailed study of the withdrawals as an integral part of the study design. The analysis can be found in Chapter VI. Since the findings concerning the families and children who did not remain in the demonstration are included in the next chapter, the analysis in the rest of this chapter is concerned with those who participated in the study to the end. It is relevant, however, to present the proportion of children who were withdrawn as against the proportion that remained. (See TABLE VI.)

It is pertinent to mention here that for those who remained in the demonstration throughout the two year period, considerable effort was made on the part of some of the placement counselors. Because this was one of the study's hypotheses, only those counselors who were vitally concerned about providing a center experience for the study children became involved in encouraging the parents through telephone calls, visits to the home and reassurance. In other words, when in their particular borough, placement counselors became aware that many families were not registering their children for the second year, (even though parents and group leaders reported that the children had enjoyed the center experience) those counselors became practicioners and intervened on behalf of the parents. Those children whose counselors were most active in intervention attended more regularly. We have thereby shown evidence unwittingly, with respect to the testing of the study's secondary hypothesis: that providing physically handicapped children with an integrated group experience in a community center could not be implemented successfully for all through the utilization of regular programs in existing community centers (i.e., without additions, or changes in personnel).

While this is analyzed in greater detail in the concluding chapter in the discussion of the testing of the primary hypothesis, TABLE IV (p. 67) shows that even one year provided evidence of more improvement on the part of a larger proportion in the Experimental than in the Control. It is also pertinent to mention that the analysis of those families who withdrew their children for reasons other than medical or moving out of the area, shows that this was not necessarily negative for the child. Withdrawal sometimes represented a growth experience for both parents and children, e.g., through finding a program closer to home,(or one more appropriate to the handicapped child's special talent), and overcoming parents' fears when child was away from home.

The following TABLE shows the number and percentage in both Experimental and Control groups who withdrew.

TABLE VI

STUDY POPULATION: ACTIVE AND WITHDRAWAL GROUPS

Group	ACTIVE		WITHDRAWAL	
	No.	Percent	No.	Percent
Experimental (170)	79	46.4	91	53.6
Control (60)	42	70.0	18	30.0

As indicated above, the discussion of findings in this chapter is concerned with the 79 Experimental children and 42 Control children who remained throughout the demonstration. However, some reference will be made to a group of 36 children who were amongst the 91 Experimental Withdrawals and who remained in the center program for at least one year.

CENTER RATING*

The centers were rated four times during the demonstration on a point scale and then divided into two general groups: those which facilitated the integration of the handicapped child and contributed positively to his experience, and those which had such a low total rating as to indicate that they gave the handicapped child very little help in this new venture. There were 21 centers with positive rating and 20 with negative. (4 of the total 45 centers were not rated because the children had withdrawn or had been removed by the Placement Counselors before the first evaluation of the centers.)

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*See Center Rating Form, Appendix p. A-28.

The following TABLE shows the distribution of the children in tthe Experimental group in relation to the center rating:

TABLE VII

DISTRIBUTION OF EXPERIMENTAL GROUP IN RELATION TO CENTER RATING

Center Rating	Children (N=170)		Completed Demonstration (N=79)		Withdrew (N=91)	
	No.	Percent	No.	Percent	No.	Percent
+	109	64.1	53	67.1	56	61.5
-	55	32.4	26	32.9	29	31.9
Not Rated	2	1.2			2	2.2
Child Moved, Not Assigned	4	2.3			4	4.4

It will be noted that over 60 percent of the children in both the continuing and withdrawal groups attended centers which had a positive rating and that 32 percent of both groups were placed in centers which were rated as less helpful to the children. Therefore, there appears to be no correlation between the quality of center service in this rating and the incidence of withdrawal. As will be seen later, many derived a positive experience from centers that fell into the group with low ratings. There are obviously many factors beyond the limits of this scale that would have to be included in assessing the sources of the child's enjoyment and benefit from the center experience.

GROUP LEADER'S EVALUATION

From the Group Leader's Evaluation form that was completed at the end of the first year of the demonstration, four questions were grouped to become an evaluative instrument. The Group Leader's responses were designated by the research staff as positive or negative.

GROUP LEADER'S EVALUATION

	Positive Answer	Negative Answer
1. What was child's attitude towards participation in activities?		
2. Does child seem to enjoy himself in group?		
3. Does he make any friends?		
4. Has child's social functioning shown any change since he joined the group?		

Two additional questions were asked in the second Group Leader form:

5. What role does the child play in the group?
6. Which word describes the child in the group situation?

When a child attended more than one group, the sum of the scores for each group was divided by the number of groups, to give a final average score.

The child was given one point for each positive answer by the

Group Leader. Where he scored as well as the Experimental group average or better, he was given a positive rating, and where below average, he received a negative rating.

Of the 79 Experimental children who completed the 2-year demonstration 50 or 63.3 percent were rated "+" by the group leader for their center experience, and27 or 36.7 percent were rated "-". It might be thought that the youngest and oldest age groups would not do as well socially as the 8,9 and 10 year olds. This TABLE shows that two-thirds of all age groups were rated positive.

TABLE VIII

GROUP LEADER EVALUATION

	RATING	
	"+" Percent	"-" Percent
Total Group	63.3	36.7
Ages 11 & 12	66.7	33.3
Age 7 and under	68.2	31.8

It is interesting to note that the average score on the evaluation of the Experimental group of 79 who completed the 2 years was 89.5 percent. The average score for the 36 children who withdrew after one year was 85.8 percent. This indicates that the group leader would not have been able to predict during the first year which children would be likely to withdraw from the center program. Since there was no baseline score on socializing ability apart from the fact that the children had not been in an integrated setting, it cannot be stated that there was greater gain in one year more than the other.

PLACEMENT COUNSELOR'S EVALUATION

As with the Group Leader's Evaluation form, a set of questions were grouped to form a rating instrument with scoring done in the same way. These questions were:

1. Does the child enjoy himself?
2. What role does the child play in the group?
3. What is the child's attitude towards participation?
4. How does the child relate to other group members?
5. What is the child's attitude towards the leader?
6. What word describes child in group situation?
7. Does he seem to have any friends?

The answers here ranged, as with the Group Leader's, from positive comments on socializing ability such as "he's a leader", "eager and enthusiastic", to negative comments such as "an isolate", "a scapegoat", "refused to participate". An additional question asked of the Placement Counselors concerned an evaluation of the leader's attitude towards the handicapped child. In the few cases where this appeared to be less than satisfactory, consideration was given to this fact in rating the child's social responses in the group.

It was expected that the Placement Counselors would have a natural inclination to see the center experience as positive for the children whom they had placed and therefore would be more likely in the final evaluation to assess the child's functioning positively than the group leaders. The latter were often fearful and anxious at the beginning about including the study child in their groups. However, despite such different frames of reference, the Placement Counselors and the Group Leaders agreed on the plus or minus rating for 63.5 percent of the Experimental children.

SOCIOMETRICS

With the pressures of time and staff, it was possible to schedule only one appointment with each group where there was a handicapped child for the purpose of giving the sociometric questionnaire. Because it was not possible to return to a group in the event that the questionnaire could not be completed, there are results for only 53 groups out of a possible 98 groups in the second year for the 79 Experimental children who continued for two years of the study. (Some children attended more than one group.)

There were 55 handicapped children who participated in this questionnaire: 37 of these were "only" handicapped children in their groups and 5 of these 37 were the only handicapped children in a second group.

The groups averaged about 10 registered children but, of course, not all of these were present at the time the questionnaire was given.

The handicapped child seemed to fare rather well in that 35 were in the top 25 percent of the group as chosen by their peers for work preference and 32 were in the top 25 percent as chosen for play preference.

In the next 25 percent of the group, 14 were chosen for work and 14 for play. This means that in the group of children who participated in this questionnaire 7/8 of the children were in the top 50 percent as chosen by their non-handicapped peers.

It is interesting to note that those non-handicapped children who showed high preference for working and playing with handicapped peers were children who were at the same time popular with their non-handicapped peers.

In the few groups where there were two handicapped children, the handicapped children ttended to chose each other more often than they chose non-handicapped children for high prefetence. Does this suggest, therefore, that integration may be accomplished more easily when there is a smaller proportion of handicapped to non-handicapped children?

THE CHANGE SCALE

Keeping in mind the many varying factors to consider and the great concern that the normal development of all of the children not be minimized, a Change Scale was designed that could be used to compare the Control group with the Experimental group who had been exposed to the center group setting as the rehabilitation variable.

To determine whether the study children showed positive or negative change, the following criteria were used:

1. Direction of child's self-image;
2. The three components of the teachers' evaluation of the child's functioning in school: academic, social functioning with peers, relationship to teacher or teachers (since few children had only on teacher throughout the demonstration);
3. Changes in the child's behavior in the home as reported by the family in the third and final interview; parents' opinion of change in his behavior at school and behavior with peers, as observed by the family.

It will be recalled that the self-image ratings were derived from information solicited from the child, the school ratings were the result of teachers' comments. The question regarding changes in the child's behavior were answered by a parent, generally the mother, at the time of the third interview.

Rating - An average was derived from the above responses and ratings of positive and negative or 0 (no change) were assigned. For the purpose of this rating, "positive" means that there was some evidence of definite improvement or that the child remained on the same positive level. An average rating, i.e., one indicating a middle range was also considered positive when it remained throughout. A negative rating was assigned whenever there was a change in a negative direction or when an original negative rating remained throughout.

In order to obtain a score that took into consideration the significance of the different components, weights were assigned to positives for 5 criteria as follows:

Positive Direction of Self-Image	3
Positive Direction of school functioning in the three areas:	
1. Academic Functioning	1
2. Social Functioning	1
3. Relationship to Teacher	1
Positive Behavior Changes in home reported by the family	1
Possible Total Score	7

The following TABLE shows the results of applying the Change Scale to the three major evaluations (the child's own, the teacher's and the parents') of the child's social progress.

TABLE IX

SCORES ON THE CHANGE SCALE

	AVERAGE SCORE	PERCENT OF GROUP
Experimental (79)	5.92	84.6
Control (42)	4.67	66.7
Experimental Withdrawal (after 1 year) (36)	5.26	75.1

It can be seen from TABLE IX that 17.9 percent more children in the Experimental group scored as high as or better than the average of their group than in the Control group. Comparing this change with the Experimental children who withdrew after one year of the demonstration, it can be seen that a little more than half of the progress appeared to have been made during the first year.

If the Experimental and Control groups are compared against the average score of both groups on the Change Scale, 77.2 percent of the Experimental and 47.6 percent of the Control had a score of that average or better -- a difference of 29.6 percent in favor of the Experimental group.

A score of 5 to 7 was interpreted to mean that a child showed evidence of progress. This score range could only be attained if the self-image direction were positive and two or more of the other items were also rated positive.

A score of 3 or 4 was interpreted to mean that progress was questionable, i.e., there was evidence of some positive and some negative.

A rating that included a self-image direction of a positive nature alone with one other area that was positive reflects some improvement but not sufficient to be designated as change in a positive direction. Similarly, a positive rating in four areas without a positive rating of the self-image direction could reflect some improvement but was interpreted as a questionable rating.

However, where the direction of the self-image was positive and the parents' evaluation of behavior of the children in the home (including the three components described earlier) was positive, this was interpreted as a positive rating even though the actual score was 4 out of a possible 7 points.

The following TABLE shows the distribution of the children by high or low score on the Change Scale.

TABLE X

DIVISION OF CHILDREN ACCORDING TO HIGH OR LOW SCORES ON THE CHANGE SCALE

	EXPERIMENTAL (2 Years)		CONTROL (2 Years)	
	No.	Percent	No.	Percent
High Score	61	77.2	20	47.6
Low Score	18	22.8	22	52.4

Since the Change Scale is the major method for comparing the Experimental and Control groups, correlations with the other variables are given here in some detail. The "average" used is the one for the combined groups.

TABLE XI

EXPERIMENTAL GROUP SCORES ON THE CHANGE SCALE

	SCORE ON THE SCALE	
	Average or Above Average	Below Average
Total - 79	61=77.2%	18=22.8%
Age:		
7 and under	27.9	27.7
8 - 10	50.8	55.6
11- 12	21.3	16.7
Sex:		
Male	54.1	77.8
Female	45.9	22.2
Ethnic Group:		
White	23.0	44.4
Negro	41.0	27.7
Puerto Rican	29.5	11.1
Other	6.5	16.7
Functional Level:		
Mild	41.0	50.0
Moderate	52.5	50.0
Mod. Severe	6.5	
Self-Image:		
Improved +	47.5	38.9
Remained +	52.5	38.9
Negative	-	22.2
Comprehensive Family Rating:		
Remained H or M	63.9	61.1
Improved	19.7	22.2
Negative or regressed	16.4	16.7
Group Leader Evaluation +	67.2	50.0
-	32.8	50.0
Center Rating +	65.6	72.2
-	34.4	27.8

It will be seen in TABLE XI that for the Experimental group: age was not a significant factor; the females made more progress than the males; the Negroes and Puerto Ricans made more progress

TABLE XII

CONTROL GROUP SCORES ON THE CHANGE SCALE

	SCORE ON THE SCALE	
	Average or Above Average	Below Average
Total 42	20=47.6%	22=52.4%
Age:		
7 and under	30.0%	18.2%
8 - 10	55.0	54.5
11 - 12	15.0	27.3
Sex:		
Male	60.0	77.3
Female	40.0	22.7
Ethnic Group:		
White	50.0	40.9
Negro	25.0	36.4
Puerto Rican	20.0	22.7
Other	5.0	-
Functional Level:		
Mild	35.0	40.9
Moderate	50.0	36.3
Mod. Severe	15.0	22.7
Self-Image:		
Improved +	45.0	36.3
Remained +	55.0	31.8
Negative	-	31.8
Comprehensive Family Rating:		
Remained H or M	60.0	40.9
Improved	15.0	27.3
Negative or regressed	25.0	31.8

than the whites; the more severely physically handicapped children did as well or slightly better than the mildly handicapped; there is a marked correlation between improved self-image and improvement in social functioning; a highly facilitating family background did not seem to be reflected in the Change Scale Scores; the group leaders at the centers gave a positive evaluation to two out of

TABLE XIII

SCORES ON THE CHANGE SCALE OF THE EXPERIMENTAL WITHDRAWAL GROUP
(After One Year)

	SCORE ON THE SCALE	
	Average or Above Average	Below Average
Total 36	20=55.6%	16=44.4%
Age:		
7 and under	20.0%	12.5%
8 - 10	70.0	75.0
11 - 12	10.0	12.5
Sex:		
Male	35.0	56.3
Female	65.0	43.7
Ethnic Group:		
White	30.0	50.0
Negro	30.0	18.7
Puerto Rican	40.0	31.3
Other	-	-
Functional Level:		
Mild	35.0	43.7
Moderate	50.0	56.3
Mod. Severe	15.0	-
Self-Image:		
Improved +	55.0	50.0
Remained +	45.0	50.0
Negative	-	-
Comprehensive Family Rating:		
Remained H or M	70.0	75.0
Improved	-	-
Negative or regressed	30.0	18.7
Group Leader Evaluation +	65.0	68.7
-	35.0	31.3
Center Rating +	80.0	68.7
-	20.0	31.3

three children receiving high scores on the Change Scale and gave a positive evaluation to half of the children with low scores on the Change Scale; the rating of the centers seemed not to be a discriminating factor in regard to improvement in social functioning as measured here.

TABLE XII giving the scores for the Control group shows: more progress for the younger children; the females again showing higher scores than the males; the whites making slightly more progress than the others; the moderately severe group slightly ahead; marked correlation between high self-image and improvement in social functioning; a facilitating family background to be of significance in improvement in social functioning.

It is not necessary here to comment on the one-year Experimental group in TABLE XIII. It is sufficient to say that most of the scores fell between those of the Experimental and Control groups, indicating that one year of experience in a group setting was better than none where social functioning ability is concerned.

FURTHER COMMENTS

The tables just presented provide evidence that physically handicapped children derive benefit from participation in group activities with non-handicapped peers. That this can be greatly extended is clear from the analysis of the withdrawals in Chapter VI which includes observations, comments and criticisms that the study parents felt free to make when interviewed for the purpose of finding out why they had withdrawn their children. Benefits to the parents and their children from their roles as participants in the study were apparent in the interviewers' notations at the end of each of the three family and child interviews. In addition, they were asked to assess this value after the termination of the demonstration, i.e., during the period that the data were beginning to be analyzed. Since critical observations of parents, which obviously includes the reactions of the handicapped children -- Control as well as Experimental; withdrawal as well as active -- lead to significant conclusions and recommendations for the community center field, a few highlights are included in these brief comments.

Probably the most significant value derived by parents through their participation in the study was the opportunity to think about their handicapped child (or children, for a few had more than one) without the contaminating influence of society's negative and discriminatory attitudes. This resulted in most instances in more realistic and more constructive attitudes and handling of the study children. In this respect, differences were noted by social class. For example, interviewers had the impression that among the middle-income families, they observed "more of an intellectual understanding of the child and his handicap than an actual change in acceptance. Lower socio-economic families, with limited goals and striving for achievement, seemed to show more acceptance for the child and his limitations." Often the potential of the handicapped child in the lower-income families with limited opportunities for development for all children in these families made the achievement and future potential of the handicapped children "not much different or less than that of non-handicapped siblings."

This is not to imply that there were not families among the low-income, minority groups who were not accepting of their child's handicap. In both classes of families, this attitude was stronger among fathers than mothers. There were instances in which the mother related desertion on the part of the father to the fact of having a handicapped child. There were, however, situations in which having the handicapped child and the necessity to provide for his many needs served "as a mobilizing force for the family and brought forth family strength."

It is not possible to show statistically the number of families whose attitudes and handling changed in a positive direction -- change that might not be reflected in the foregoing tables of comparison of the Change Scale ratings of the Experimental versus Control; active versus withdrawal. Time is required for significant change in parental attitudes, and for some families problems served to delay the value of the involvement as participants in the study. The small proportion of resistant and hostile families suggests that in different degrees it was beneficial to have the opportunity to begin to think for the first time about things they had suppressed, and to have a chance to raise questions and re-discuss with an understanding person the problems of rearing a physically handicapped child. Mothers' own comments, negative as well as positive, obtained after completion of the demonstration project, reflect this and will be summarized in the concluding chapter.

This has been an unusually long chapter for a report of this length. However, in the absence of detailed studies about handicapped children, it seemed important to describe in full the sources of the evaluation of these children in their families and to expose the interdependence of all of the factors that were considered.

CHAPTER VI

ANALYSIS OF THE WITHDRAWALS

The research design was broadened to include analysis of the children who did not continue in the demonstration throughout the two year period. This was based on the assumption that much would be learned from this group that might otherwise be lost if the analysis were delayed until after the termination of the demonstration. Accordingly, when, during the first year, it became apparent that children in the Experimental group were not returning to the centers,* a social worker who had not been involved in the family-child interviews was assigned responsibility to do some experimental interviewing by telephone to find out whether parents would be interested and willing to give us their reasons for the withdrawals.

It was explained that their willingness to discuss why the child had not continued would be helpful to us in many ways, particularly to be able in the future to anticipate some of the problems that had developed. The interviewer also indicated that the center selected might not have been the most appropriate for their child; or the family might have had reservations about having the child included in the demonstration that were overlooked.

Most of the parents were pleasant, willing to talk, and appreciative of the agency's interest. It had been hoped that this would be the case because of the kind of relationship that had been established with the study families. In addition, it was assumed that parents who had withdrawn their children might have some guilt feelings about not utilizing an opportunity that was based on the agency's efforts to provide a constructive experience for their handicapped child. The response from this first group of parents was encouraging. Accordingly, a brief interview schedule was designed for use in the interviews with parents whose children had been withdrawn before the second family and child interview. The following is a condensed form of this schedule.

---

*We did not know about the Control group withdrawals until the second family-child interviews.

WITHDRAWAL FAMILY INTERVIEW

Case #

(For all inactive families)

As you know, our study at the New York Service has been concerned with the whole question of placing handicapped children with non-handicapped children in community centers. We know that for some children this may be a good plan and for others, it may not be.

Since you were part of the study for awhile, we would like to ask you some questions about the experience.

We knew that there would be reasons why some families could not continue or would not be interested. It would help us in improving programs and in future planning to get your reactions, negative as well as positive.

We are very much interested in learning about the experience your child had while he was in the demonstration.

COMMENTS: ____

____

1. What contact did you have with anyone from our agency or the community center regarding registration of your child at the center? - or with re-registration?

   ____

   ____

(These questions are from the 3rd Family Interview.)

2. Did *________ attend any neighborhood center or group other than the one to which NYSOH referred him during the last year?

Yes ( ) No ( )

3. What center? A. Integrated ( )
B. Segrated ( )

3(a). How did he like it?

Comment__________________________ 1. Positive experience
__________________________ 2. Noncommittal
__________________________ 3. Negative experience
____
____

CHARACTERISTICS OF THE WITHDRAWAL GROUP

We had by this time learned that a number of families withdrew their children early in the demonstration, or had failed to register the children in order to take advantage of elective surgery, plans for which had been made some time before the family's agreement to take part in the demonstration. Other families had moved out of the metropolitan area; some, notably those from the Spanish-speaking group, returned to Puerto Rico. A small number of children (five in all) had to be withdrawn because of problems in the center. Since there was no other center program to which the children involved could be assigned, they were continued in the agency's counseling program.

As was mentioned earlier (See TABLE VI, p. 81) 91 children of the Experimental group of 170 children did not remain in the demonstration for the two-year period; similarly, 18 of the 42 Control children were withdrawn before the end of the demonstration.

The reasons for withdrawal from the center programs did not appear to be related to the degree of disability, as over half of the children who withdrawn were in the "mild" group, that is, having the most nearly normal level of functioning ability, as can be seen from TABLE XIV.

TABLE XIV

DISTRIBUTION OF ACTIVE AND WITHDRAWN CHILDREN ACCORDING TO FUNCTIONAL LEVEL

Group	Total Number	Functional Level		
		Mild	Moderate	Mod. Severe
		Percent		
Experimental	170	47.6	45.9	6.5
Active	79	43.0	51.9	5.1
Withdrawn	91	51.6	40.7	7.7
Control	60	35.0	50.0	15.0
Active	42	38.1	42.9	19.0
Withdrawn	18	27.8	66.6	5.6

Further, in the Experimental withdrawals there was:

- a somewhat higher proportion of females;
- no significant difference in regard to age;
- highest proportion of withdrawals in the white group, followed by the Puerto Rican;
- highest proportion where there was only one parent in the household;
- highest proportion of withdrawals where the study child was an "only"child;
- highest withdrawals in Brooklyn; and Queens where there was the least amount of intervention on the part of the Placement Counselors;
- lowest withdrawals from the highest income bracket;

- lowest withdrawal from the college educated parents.

In the withdrawals from the Control group, there was:

- a slightly higher proportion of males;
- a higher proportion in the youngest age group;
- the highest proportion in the Puerto Rican group;
- a higher proportion in intact families (both parents);
- the highest withdrawal from the highest income bracket;
- the highest withdrawal from the college educated parents.

It is apparent from the above listing of characteristics that the differences between children and families remaining in the demonstration for the two-year period and the withdrawals were not significant in regard to major identifying factors such as age, sex, or functional level. However, it is noteworthy that the lowest proportion of withdrawals from the Experimental group occurred in families having the highest income and educational levels. This suggests the need to interpret to low-income and minority group families the importance of utilizing existing community facilities and to assist them in stimulating the creation of facilities for areas where none exist.

There were some families who were able to gain from the experience of the child and family interviews with the trained research staff and who, after only one-year of participation, were able to substitute family recreation (for the first time) or other group activity in their immediate neighborhood. Lower income families as well as middle-class families began to view their handicapped children as being able to participate in family activities which formerly were thought to have some detrimental effect.

In other words, withdrawal from the demonstration was not necessarily a negative step. On the contrary, it often represented a growth process for the parents, the non-handicapped siblings and the study child.

The following is an illustration of a positive reason for withdrawal that highlights the ingenuity of the mother in making her own arrangements for her daughter's involvement in group activity.

> The girl is aged 9, white, with a diagnosis of cerebral palsy causing spastic paraplegia. Her physical functional level was rated 'mild' and she walked with a slight limp. The family was rated 'facilitating.' The girl was in a regular class at school.
>
> The family consists of the mother and two daughters. Mother works as an executive secretary; father has been out of the home since the study child was three years old. Grandparents are close to the family and grandfather serves as a father substitute.
>
> At the time of the first family interview, mother was very interested in providing a community center experience for her handicapped child. Arrangements were made for the child's participation in a Girl Scout Troop, which required transportation by taxi. This arrangement was upsetting to the child. The mother managed to discover that another Troop would be formed nearby in the child's school.
>
> It was learned later on in the follow-up interview that the troop near their home had indeed been formed and that the child had participated and was enjoying it immensely. In fact, she was being promoted to a junior high school where she would be continuing her girl scout activity. She was also attending a camp for C.P. children, where she had been made an assistant to the arts & crafts specialist.

It is unlikely that this mother would have been able to take the initiative just described if the family and child interview had not encouraged her to see the importance and value of extending the sphere of the handicapped child's activities.

REASONS FOR WITHDRAWAL

Reasons That Could Have Been Anticipated.

Medical. Withdrawal of study children for medical reasons such as need for surgery should have been anticipated by an agency which runs a summer camp for handicapped children. Experience of the camp staff has shown that last minute "drop-outs" frequently occur when the physician suddenly realizes that it is summer time and "something must be done" while the child is not attending school. Then follows the scurry to find replacements so that precious camp beds will not be wasted. Unfortunately this knowledge was not transferred to the project planning staff, and therefore, appropriate questioning of parents and attending physicians was omitted in the intake interviews.

Of the 91 withdrawals from the Experimental group, 23 withdrew for elective surgery, plans for which must have been made before the family's agreement to participate in the demonstration.

With more careful screening in the determination of eligibility, the number of withdrawals for medical reasons could have been greatly reduced.

Ignorance of center procedures. A second reason for withdrawal that might have been anticipated was the reaction of the parents to center procedures and the general milieu. Parents as isolated from community life as these parents have been should have had preparation for this experience. They had never been in a center and found the atmosphere confusing. They were fearful that the large numbers of people whom they saw on registration day would be upsetting to their handicapped children. They were disturbed by the noise, seeming casualness and confusion.

It would seem that preparation through discussion or, better still, a pre-registration visit to the center for these parents, and in fact all parents and children unused to this setting, would have lessened these negative impressions. For the study families in particular, this preparation would have reduced the number of early withdrawals. Further, some of the parents needed help in registration procedures including alternatives when they could not pay the fees.

Placement problems. A small number of placements were made that overlooked racial overtones and the overt prejudicial attitudes that were prevalent in racially mixed neighborhoods. Failure to take into consideration the increased fears and tensions of white families in mixed neighborhoods was responsible for inappropriate placement of, for example, a single white child in an activity group of black children.

The following is a graphic example of the fears and stereotypes affecting Negroes by a white family living in a racially mixed neighborhood. The mother told the interviewer in the first family and child interview that they were "terrified" of the large number of Negroes living near them. The mother also reported that the study child had been "molested," and that she was fearful of Negroes. (The record does not include any details and the interviewer suggests that the above accusation may have been an expression of the family's fear and prejudicial attitude toward Negroes.) The child was assigned to a center and, unfortunately, was the only white child in what the family described as all black groups. By the time of the follow-up interview, it was not possible to obtain additional verification.

Unfortunately, the information apparently did not reach the Placement Counselor in time and the child had been withdrawn by the parents by the time of the research follow-up interview.

In retrospect this problem should have been anticipated. The family's fears should have been discussed in the first research interview and the outcome passed on to the Placement Counselor involved for his use in making that child's placement. It is, of course, possible that frank, open, and understanding discussion of the parents' attitudes vis a vis Negroes might have resolved the problem, though this cannot be confirmed at this late date. Certainly, a different placement should have been arranged.

Fortunately, this was not a widespread problem though some comments by parents, critical of the center programs, had racially discriminatory overtones.

In contrast to the above illustration, it should be noted that for some of the study children the opportunity to get to know children of a different race or religion was a constructive learning experience. For example, a Catholic child, who returned home after witnessing and participating in a colorful Jewish festival at the center, announced excitedly to her parents that she wanted to become a Jew. In another situation, illustrative of the influence of involvement of young children in community center activities, a mother who had rarely visited the center was pleasantly surprised by the praise she received for her child from parents of a different racial group and religion.

Had the increase in prejudicial attitudes on the part of a predominantly lower-class group of white families toward Negroes and Puerto Ricans been anticipated, questions regarding this could have been introduced into the first family interview schedule with the objective of providing greater inter-group understanding and consideration, and parents could have had a choice of placement, dependent upon their understanding. In any case, parents should have been informed of the predominant character of the groups served by a given center. Because of the prejudicial attitude on the part of whites, the Puerto Rican children did not come to life in the center activity unless some of their own group were there. It should not have been surprising.

Another placement problem was the necessity to place children in centers outside of their immediate neighborhood. Many children felt isolated from their friends who either did not go to any center or attended another center. (These were sometimes non-handicapped; sometimes physically handicapped). In families that were not facilitating, such children became discouraged early in the program when the non-handicapped children tended to stare, question, admire, or make fun of crutches or otherwise embarrass the study child, and would drop out. Those who gained some support from their parents were able to continue and to be ingenious and creative in how they explained their disability. Sometimes support from a teacher encouraged the child to talk about his center experiences to the class, or made it possible for the child to show his peers what he had learned. It should be noted that the study children were invariably a small minority -- sometimes a minority of one or two. It is, therefore, a tribute to the untapped potential of the physically handicapped children that with all of the problems involved, both anticipated and unanticipated, so many remained in the demonstration throughout and emerged from the experience with an improved self-image -- if it was not high to begin with, or one that was not negatively affected by the new experience.

With two-thirds of the study population made up of either Negro or Puerto Rican families, it is not surprising that many parents were too beset by so many problems in the home to provide the necessary support to the child because of behavior problems of siblings; domestic friction through overcrowding; resentment on the part of the non-handicapped siblings towards the study child since they were not attending the center. This latter was somewhat ameliorated by having the interviewers bring colored paper and crayons for all of the children in the family.

Follow-up Practices. Of all the problems that should have been anticipated by the staff, perhaps the most significant one for this study is the usual center practice of not following up on children absent from program. This problem cut across social class, ethnic and religious affiliations, and child-rearing practices of all the families. Although this practice would be expected to affect the attendance of non-handicapped children, it made a more serious impact on the handicapped children in families where there were no other problems that would have made for withdrawal. The following comment from a mother interviewed regarding her child's withdrawal is illustrative of the parental concern and surprise when no notice was taken of a child's absence:

> I was very disappointed when no one from the center contacted me. If someone had called and shown interest, he (the study child) would have returned.

> 'What if,' she continued, 'I or the taxi left him at the entrance and he never got to the group. No one would ever know the difference. No absent card was sent.'

The writer was unaware of the high percentage of turnover in the "normal" clientele of the centers. (Some directors have estimated the turnover to be as high as 50 percent.) Therefore, no investigation was initiated before the beginning of the project to ascertain the major reasons for withdrawal of "the normal" children from center programs. Had this practice on the part of centers been known, the secondary hypothesis would not have been included as part of the research design, as it would have been obvious that some follow-up would have been needed for the handicapped group.

Upon further investigating it was found that there was nothing unusual in the high proportion of turnover of children attending center programs. In such a popular program as the Boy Scouts of America, it was a surprise to the writer to learn informally that over 50 percent of the boys between the ages of 11 and 18 had belonged to that organization only one year or less.

If the importance to the group of handicapped children of the center practice of not following up the absences had been realized, it would have led to building into the responsibilities of all of the Placement Counselors a routine for follow-up.

Parental Attitude. Differences between parents as to the value of placement in an integrated group activity program, with the father usually taking a negative view, was surprising. In a few instances, this was due to misunderstanding about integration in the center programs. More frequently, it was due to a denial on the part of the father that the child had a physical disability.

The following situation is illustrative:

> The child in question -- a 6-year old Negro boy -- was one of five children. The diagnosis is quadriparapetic post trauma (child was hit by a car), moderate ataxia; often falls. He attended a health class. Functional leval was 'mild'. The family was living in a four-room, two-bedroom apartment. Father is a high school graduate; mother has had 10 years of school. In the initial family interview, the father was not interested in the center program.
>
> He said: 'the child does not consider himself handicapped.' The mother was only moderately interested. Ho wever, the child attended the center the first year, where he did well and enjoyed it. At the end of the first year, the mother told the interviewer that the child seemed to like everything about the center even though she didn't think he learned very much.
>
> When the child failed to return to the center, the research interviewer telephoned the mother. The latter explained that the father did not want the handicapped child to attend the center where others were 'worse off than he.' After some discussion the mother stated that she believed the father would allow the child to return to the center since he had gotten so much enjoyment from the experience. However, this did not materialize.

In the inactive follow-up interview, the mother said that the father had made the decision but had given her no reason. The interviewer then spoke to the father who than said: "The child doesn't need'special favors' as he is a 'normal' child." The child stated that he stopped going because of "my birthday."

Aside from the difference between parents regarding the child's need to accept his handicap, there is some evidence that became clearer in the follow-up interview that the mother was overprotective and preferred keeping the child with her. The father continued to deny the child's handicap. Accordingly, both parents would have needed more interpretation about the center and encouragement to help the child remain in the program. They would also need counseling to accept the child's handicap. Counseling was offered at the end of the demonstration but parents made clear they were not interested. It is to be hoped that adults outside of the child's family will enable the boy to accept his handicap and stimulate him to fulfill his potential notwithstanding.

Although more careful interpretation of the meaning of an integrated group activity might have affected this father's attitude toward his child's placement in the center, his denial of the child's handicapping condition could not have been anticipated in light of the medical referral. Similarly, the father's refusal to have his child associate with children "worse off than he" could not have been predicted.

It is pertinent to note here that figures have not been given for the different reasons for withdrawal because in many instances (as seen in the last illustration) more than one factor was responsible. Further, not all of the categories are mutually exclusive and not all of the families who withdrew their children could be located for questioning.

Reasons That Could Not Have Been Anticipated.

As was noted in the section on reasons that could have been anticipated, there is overlapping in significant factors affecting reasons for withdrawal. These are described below. The main emphasis in this chapter has been on identifying problem areas from which recommendations flow, as well as problems that are essential for any replication of the study.

Family Problems. It should be noted that many family problems antedated participation in the demonstration, and these were not known at the time of the first family interview and could not have been anticipated. A considerable proportion of the withdrawals in this category were due to serious or terminal illness of a parent, marital problems, desertion of the father when he became unemployed, differences between parents about the value of placement in a group activity program -- whether integrated or segregated. This latter became an issue as a result of the child's participation in the demonstration. It occurred when a child who had not resisted parental overprotectiveness (sometimes from one; sometimes from both parents) began to show signs of resistance through a new-found independence. In other words, the over-protectiveness was not discernible in the first family interview. It is possible, however, that it could have been noted since there were two interviewers in the early phase of the first family and child interviewing who did not have social work training and experience. It is also possible that the over-protectiveness manifested itself in the handling of the child later in response to the child's changed behavior.

Death of a parent or break-up of a family through marital difficulties accounted for some of the withdrawals in this group. In a number of instances, parents had not anticipated the amount of time that would be involved in the participation and withdrew the child so that he would not fall behind in his school work, or because they had already been informed the child was falling down in his school work. In a few instances, placement interfered with the child's formal religious classes. Children also found the experience of having a taxi take them to the center and home gave them a kind of status with non-handicapped peers who had previously avoided them,* but were now ready to accept them. The attraction of playing near home with children who were not formerly their friends apparently outweighed benefits the children had indicated they were deriving from the center experience. In other instances, children who had friends in their neighborhood and were afraid of losing them wanted to withdraw. In this small group of children, it is not possible retroactively to indicate whether the child might have remained in the program if parents had provided more support early in placement. It is understandable that the attraction of friends in one's own neighborhood might have been more compelling to physically handicapped children even with a great deal of support from the family early in placement. Where it appeared that the child had influenced the withdrawal, questions were asked of the child in the follow-up interview of the inactive families, and confirmation of this reason was obtained.

In addition to the general objective of ascertaining the family's reasons for withdrawal, there was the objective of finding out whether more skillful interviewing in the initial phase of the family and child interviews might have reduced the number of withdrawals. Accordingly, following the telephone interviews with parents, examination of interviews with families that the writer had labeled "risk" cases was undertaken . Also included in this examination was a sampling of interviews by the two interviewers who had displayed weakness in the pretest interviewing but who were continued for an additional period because of pressure to complete the interviewing before the beginning of the center programs in October.*

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*Many parents of children who do not have physical handicaps are uneasy when their children play with the physically handicapped; partly because of the association with polio; partly because of the age-old stereotype.

This proved productive so far as a correlation between skillful interviewing and the ability to discern ambivalence, fear of responding negatively to what even over-protective parents recognized might be of value to the child, and over-protectiveness that was hidden beneath a serious marital problem in which difference regarding the handling of the child was the major overt manifestation. The examination of the so-called "risk" cases was not productive, if the group as a whole is considered. Some of these "risk" cases had not only continued in the demonstration but had done extremely well, despite functional disabilities that could have constituted a serious obstacle. In other "risk" cases, where the family had been rated as deterring, the child remained in the study throughout, and showed evidence of considerable gain from the experience. The most striking illustration of the former was that of a boy with a severe speech difficulty who was making a remarkable adjustment, was popular with the non-handicapped in the groups, was enjoying the experience and was improving in other aspects of his functioning.

SUMMARY OF THE WITHDRAWALS

Without the data obtained initially through telephone interviews and subsequently by means of interviews with parents in the home, the statistics alone would have presented a grossly inaccurate picture of the withdrawals.

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*It will be recalled that there was a change in research directors between the determination of a family-and-child's eligibility and the designing and carrying out of the first research interview with the family and child in order to have a baseline against which to measure change in either direction, negative or positive, before placement of the Experimental group.

As noted earlier, a smaller proportion of children from the Control group than from the Experimental group were withdrawn from the study. This is understandable. The reasons were medical, mobility of the family, and lack of interest on the part of parents in continuing, i.e., participating in the family-and-child interviews. It will be recalled that a majority of the Control families had middle-class status, though their problems in acceptance of the handicapped child were on a more intellectual basis in many instances than was the case in the lower-income and minority group families.

It is apparent from the analysis of the circumstances under which children in the Experimental group were withdrawn that parents were encountering problems in connection with participation in the demonstration. A larger proportion of these problems could and should have been anticipated. Had this been the case, the secondary hypothesis of the study would not have been included in the research design. It stated that the integration of physically handicapped children in organized group activity programs could be implemented successfully through the use of regular programs in existing community centers, without additions or changes in facilities or personnel. As mentioned in Chapter V, the above hypothesis is not confirmed by the study findings. On the contrary, the fact is that in two boroughs -- the Bronx and Manhattan -- there were fewer withdrawals proportionately. This fact was due largely to the intervention and assistance which the Placement Counselors in these two boroughs gave to the families.

It would appear that the influence of the center's practice of not following up absences of any of the children in their programs had not been viewed as center policy by the Placement Counselors. The latter were so convinced of the value of involvement of physically handicapped children in integrated group activity that they overlooked the effect on these parents of their unfamiliarity with community centers. Furthermore, the Placement Counselors saw little value in research aspects of the demonstration. At the beginning of the study, they made clear that the money used for the evaluative research might be better spent in service, that is, in sending more children to centers. The writer soon found that the attitude noted above was a common one in the Group Work field.

Accordingly, the writer who, as indicated earlier, was not familiar with the community centers was stimulated to ascertain the status of research as well as attitudes about research in this field of social work. A study, Five Fields of Social Service: Reviews of Research, published by the National Association of Social Workers, Inc. (Ed. H.S. Maas) in 1966, confirmed the widespread lack of research interest and involvement of "building centered agencies like the settlements, 'Y's', Jewish Centers and Boys' Clubs; and program centered agencies like the Boy Scouts, Camp Fire Girls, and the B'nai B'rith Youth Organization ....." This served to explain the quasi-total rejection of the value of research on the part of the Placement Counselors.

The following excerpt from the above mentioned study is in a section by Dr. Arthur Schwartz called "Neighborhood Centers." He notes that these agencies operate:

> in the heart of the American urban neighborhood and are historically connected, in varying degrees, with

> the field of social welfare and the profession of social work. As such, they have a potential as yet only barely realized for affecting deeply the scope and quality of the social welfare performance where it is most needed."

Even more relevant is his conclusion that realization of this potential will depend on the "extent to which these agencies can follow both the field and the profession into a closer relationship with science and research."

CHAPTER VII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

This report is concerned with findings from a study involving 230 orthopedically handicapped children who participated in a two-year demonstration of the effect on children's mental health of organized group activities in community centers and settlements. Mental health was subsequently defined as the child's social functioning in the home, in school and as reflected in the child's self-image.

The study's major hypotheses tested were that: (1) the mental health, as defined above, of mildly orthopedically handicapped children is improved through participation in after-school recreational activities in community centers with their non-handicapped peers; and (2) that their integration in the New York City neighborhood centers can be accomplished without the employment of special and/or additional center staff or the need for special training of staff or equipment.

The 230 study children, aged 6-12 years, were divided into an Experimental group of 170 children, and a Control group of 60 children. There were 91 withdrawals from the Experimental group, leaving 79 children who attended the center programs for the two-year demonstration; and 18 withdrawals from the Control group, leaving 42 children on whom all significant data were collected. The reasons for withdrawal were analyzed, and they made a contribution to the understanding of handicapped children and their families. It was found that many of the withdrawals had a positive experience at the centers, especially those who continued for at least one-year. Families who had not formerly made an effort to make recreation plans for their handicapped children began to seek other suitable play-groups for them, or to include them in family activities.

Data were obtained through interviews with the study children, their parents, their teachers, their group leaders and their Placement Counselors. All of the families were given a Comprehensive Family Rating. All of the children were given a Self-Image score and a rating by their teachers. In addition, the Experimental children were given a rating by their group leaders and Placement Counselors and were rated in popularity by the others in their recreation groups.

Comparing factors concerning the families, the school and the children's self-evaluations, it was found that more of the Experimental children showed improvement in social functioning than did the Control children. Some of the Experimental children showed quite marked improvement. This improvement was attributed to the rehabilitation variable -- the experience of associating with their non-handicapped peers.

The first hypothesis was, therefore, proved. However, the second hypothesis -- that the handicapped children could participate in the programs without special or additional staff -- was not proved. It was found that the long isolation of these families from community life ill-prepared them to cope with problems of transportation, registration at the centers, seeming indifference on the part of center staff to absences, and the constant need to support their children through the many unfamiliar occurrences in recreational integration.

BUT -- this program of integration was considered to be most successful. The children played together without prejudice and many staff members at the centers learned that handicapped children are children.

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

> To date it has been extremely difficult to isolate the influence of group service institutions on particular children. We are able to show how a child learned to swim or to cook or to make things, but we have not been able to isolate those phenomena that show changes in attitude, behavior, or self-image.
>
> Graenum Berger.
> Member of the
> Technical Advisory Committee

A significant -- if not the most significant -- conclusion of this study is the fact that techniques were developed that made it possible to note and assess changes in attitude, behavior and self-image of the study children. Replication of the study will be essential to test the objectivity and validity of the method of evaluating the effect on the children in the Experimental group of the rehabilitation variable. These techniques are the Self-Image Evaluation, the Comprehensive Family Rating, and the Change Scale. The two former are described and illustrated in detail in the two Monographs. They are summarized with a few illustrations in Chapter V.

Accordingly, the major hypothesis (that "the mental health of the handicapped child, defined for the study as the child's social functioning in home and school and as reflected in his self-image, is improved through participation in after-school recreational activities in community centers with their non-handicapped peers,") is confirmed. Children in the Experimental group benefitted from participation in the demonstration even if they did not remain throughout the two-year period. Some children gained even though their parents had not registered them at the center assigned through the family's success in locating a program that did not require transportation out of their immediate neighborhood.

The secondary hypothesis, that their integration in New York City neighborhood centers can be accomplished without the employment of special and/or additional center staff or the need for special training of staff or equipment, is not confirmed. Parents needed pre-registration information and guidance as well as a variety of interventions. Transportation at a distance from the study child's home together with placement problems, in particular those due to the persistence of stereotypes on the basis of color and cultural differences, constituted additional obstacles. These and the absence of a policy of follow-up of absences from program accounted for the majority of withdrawals.

In addition to testing the above-mentioned hypotheses, the study was concerned with finding answers to the following questions:

> What is the attitude of community center personnel toward serving orthopedically handicapped children?
>
> What changes were observed as a possible result of participation in the project?
>
> What was learned that would facilitate effective casefinding and referral techniques for placement . . in centers?
>
> What predictive criteria can be developed for the selection and placement of these children in centers?

*What additions to existing knowledge regarding behavior and adjustment of orthopedically handicapped children and their families could be found?

It will be noted that except for the last one, they fell within the Project Director's expertise. They are answered partially in a paper by the Project Director and one of the Placement Counselors that was presented at the Annual Meeting of the National Conference of Jewish Communal Service in 1968, entitled: "Obstacles in the Social Integration of Orthopedically Handicapped Children." It describes some of the problems encountered in the demonstration that have been discussed and illustrated in previous chapters -- in particular, Chapter VI. It also reports results of a questionnaire, which the Project Director had sent to the centers in which the Experimental children had been placed, for the supervisors of programs to answer. It lacks, however, an analysis of the responses which were received from 25 supervisors. Only a minority of the 25 indicated that special facilities were necessary, though more than half found it necessary to provide support and guidance to the group leaders.

Without an analysis, it is not possible to draw any conclusions from the responses. Nor do they support the suggestion the authors make to the effect that the community center field can serve as "the catalyst and coordinator" ... for schools and hospitals ... "to cut across organizational barriers to serve the entire community."[1]

The conclusion reached on the basis of the study findings, from the writer's point of view, is that only the public school

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*This question is discussed in a later section of this Chapter.

[1] Harold W. Robbins and Regina Schattner, Journal of Jewish Communal Service, Vol. XLV, No. 2, Winter, 1968.

system has the potential of assuming the role projected for the community centers, once the schools get over the growing pains involved in the present process of decentralization. So far, as the community center field is concerned, it has too many problems in its current functioning and attempts to be relevant to a changing urban population in the metropolitan New York area for it to assume the additional role suggested above, on the basis of the present study findings. First, the field would have to be committed to research, using the term in its simplest meaning. Accurate record-keeping of the members of an activity group would have greatly facilitated the demonstration and its evaluation. As Schwartz' study, "Neighborhood Centers," makes clear and as was evident in this study, there is a lack even of "official curiosity." Schwartz refers to a second problem that stems from the first, namely:

> Despite, or perhaps because of, the heavy recording emphasis in the formal training of group workers, the agencies have never given more than lip service to the discipline of documenting their work with people. The problem goes beyond the narration of events or the recording of 'process'; even the development of uniform statistical procedures, such as common definitions of units of service, remains about as it was twenty-five years ago, when the U.S. Children's Bureau made a valiant but short-lived effort in this direction.

The lack of follow-up of absences is related to failure to keep such records, e.g., even of attendance on an on-going basis. And finally, there is the fact as Schwartz indicates:

> Social workers still tend to view systematic inquiry as an alien task, rather than as part of their professional equipment. This alienation increases the dependence of the agencies on outside experts. Also, the research interest, when it appears, is often expressed in a kind of perfectionism --

> wherein a study design is either very intricate and ambitious or it is not, 'research' at all.[2]

It is not implied that "neighborhood" centers do not and will not have a significant role in providing integrated group activity experience for orthopedically handicapped children. It is, however, implied that ohly the schools serve all children, except for a proportion from middle-and-upper-income families who use private schools and who generally have fewer such handicapped children; or if they do, are financially able to make possible fulfillment of their potential in ways that are not within the means of the two-thirds of the study population -- Negro and Puerto Rican children. It is only the public schools that could provide informal group activity programs in or near the school that are not necessarily modeled after the programs in community centers. This does not rule out a partnership between centers, settlements and the like and the public schools in creating more formal programs comparable to those in neighborhood centers.

What the writer has in mind on the basis of the foregoing conclusion is the creation of small local groups on the basis of children's creative interests or talent, e.g., music, art, painting, as well as the customary activity groups found in the centers. The writer also suggests that these informal groups should be supplemented by parent groups, so that mothers of physically handicapped children can move out of thwir isolation and become active members in their neighborhood and learn -- as the children will, if the schools become truly integrated -- that difference is not to be feared. A basic assumption for this kind of role for the public schools is that they have a major responsibility for the rehabilitation of all children but especially the handicapped, and that fulfillment of a child's potential is an integral part of rehabilitation.

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[2] William Schwartz, "Neighborhood Centers," Five Fields of Social Service: Reviews of Research, Henry S. Mass, (ed.), New York: National Association of Social Workers, Inc., 1966, p. 183.

A primary goal of the informal groups projected for schools would be to provide young children, and their parents, an opportunity to get to know children who are different by social class, color, religion and ethnic-cultural background. Today's children and their parents -- but particularly the children -- need to be helped to learn early that such differences are a part of belonging to the human race and a source of the wealth of a country like the United States, having diversified kinds of people. The advantage of having schools assume this kind of role is that parents would be more likely to relate to school program, especially if it were presented and staffed with the help of people from the neighborhood.

If this stimulates community centers to consider seriously the importance of serving all in their community, this would be an added benefit, for the schools need to learn from the centers. And the need is so great that there is no fear of competition -- only a need for cooperation. The school's lack of experience can lead to innovation aside from the fact that not all children are interested in the kind of activity programs of community centers. Further, the cooperation can lead to creative innovation on the part of both institutions.

A question arises as to whether parents would support after-school programs for children, parents of the "normal" as well as of physically handicapped children and children with a variety of other types of disabilities. Answers to hypothetical questions are unreliable. Answers to this question have to await the creation of integrated activity groups of a wide variety sponsored by and held in the schools, and/or in community centers in the school neighborhood and sponsored jointly.

A more relevant question and one that can be answered on the basis of the study findings is: "Will the parents of the handicapped be receptive?" If the parents of the orthopedically disabled children in the study are representative, on the basis of the statements of the parents, in particular the mothers, they are likely to be most receptive.

Additions to Knowledge about Families and Children.

The question cited earlier in this chapter (p. 120) having to do with additions to existing knowledge regarding behavior and adjustment of orthopedically handicapped children and their families has been answered in the findings in Chapter V. There are significant additions to existing knowledge for this is a first comprehensive study dealing exclusively with orthopedically handicapped children and their families, both of whom were considered participants in the study and were interviewed in depth three times over a two-year period. This is apparent from the frank exchange between the research interviewers and parents and the free and meaningful communication with the handicapped children. This is in addition to the knowledge gained from the Master's Theses (cited earlier) dealing with the study population supervised by the writer.

Generalizations about these parents are not productive for while they had much in common, they also had many differences. More important is the evidence that they are like parents of "normal" children with differences in child-rearing philosophies and practices chiefly by social class, and color which includes economic factors as well, and minority group status. The authors of "Family Structure and Composition: Research Considerations," conclude their research findings with the following reservation that has applicability to the different kinds of families in the study:

> Some familiar generalizations about the adverse effects on children of growing up in fatherless homes are subject to qualification and possibly to challenge. Relevant research is plagued by the difficulty of separating the effects of poverty, color, and fatherlessness as well as by questions used for determining and predicting psychological attributes.

The authors also stress the importance of accuracy in any generalizations, and point out the importance of combatting stereotypes since this becomes more difficult as "research findings proliferate."[3]

To this must be added the influence of handicapping societal attitudes. And it is the latter that makes for the greatest difference between these parents and parents generally. The involvement in the research interviews helped most of the families to break down the wall of the isolation that prevented and still prevents them, though to a lesser degree, from utilizing more effectively existing community agencies and pressuring for additional ones not now in existence.

This conclusion is confirmed in part by the degree to which the study parents felt free to be critical of the family interview, specific questions, examples of which the following are illustrative. It is significant that many parents after the first research interview began to object to the use of the word "handicap." As one of the interviewers put it: "It was as though by using the term "handicap" the study staff were in a sense segregating their child by giving him this designation. Generally these reactions were on a non-verbal level, though some expressed their dislike of this categorization openly." The interviewer adds:

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[3] Elizabeth Herzog and Cecilia Sudia, reprinted from Race, Research and Reason: Social Work Perspectives, New York: National Association of Social Workers, 1969.

> Many also reacted negatively to the question asking them to describe their child. They did now know, and probably speculated on our motive for asking the question, with the result it served to inhibit many who gave sparse answers. Some said it was a bad question. Others did not like some of the 'agree-isagree' statements, and this also may be related to their objections in being singled out as a group.

On the other hand, many parents thought the "agree-disagree" series statements "which did not direct sensitive questions pointedly at them, seemed to be less threatening and enabled them to express more freely and openly their own personal feelings and experiences. One mother of a child who had been withdrawn from the Experimental group was able through the "agree-disagree" series to express a feeling of guilt that she had carried for many years, i.e., that she was responsible for her child's condition because she had worked and worn a tight girdle to conceal her pregnancy."

Many parents thought "out loud" for the first time about "various aspects" of their child's disability and of handicapping conditions other than orthopedic. Mrs. "B" first expressed an opinion that there should be integrated classes for all handicapped children, except for the blind. But as she continued to give this some thought, she changed her mind and felt that the blind could learn to get along in integrated classes if they were given this opportunity. Another mother concerned about the sluggishness of her child brought this up with the interviewer and in the process remembered that she had neglected to check the child's prescription for pheno-barbitol again with the neurologist. (The child had been withdrawn from the Experimental group.)

The foregoing is in addition to the knowledge gained about the study families that is included in the Monograph: "Families in Trouble: A Comprehensive Family Rating Technique," which includes its relevance and significance for social work practice.

As regards additions to knowledge concerning the physically handicapped child, the Monograph: "They Can Communicate: Self-Image Evaluation" provides ample evidence of this and its applicability to social work practice, a small part of which has been included in Chapter V. Pertinent here is the conclusion that for the physically handicapped child, the major handicap is society's indifference and the resultant lack of opportunity for self-fulfillment.

If, on the basis of three depth interviews with parents and the study child over a two-year period combined with participation of their child in the demonstration for the Experimental group makes possible the kind of receptivity and interest in learning that the research interviewers reported, how much more receptivity and learning is likely to be manifested if these parents were involved in helping to form informal groups for their children, non-handicapped as well as handicapped, and comparable groups for parents?

Similarly, if three short interviews with teachers, since they had to take place during school hours, could stimulate them to be interested in looking into the possibility of centers for children, how much more of this interest might be available if activity groups were formed within, or in the vicinity of, their school? Because of "bad neighborhoods" from which many of the children come, one teacher from Queens felt that "supervised recreation centers were doubly important." A Brooklyn young and new teacher "found the interview very thought-provoking and stated that it had stimulated her to review many aspects of her handling of handicapped children." Negative reactions to the school interview were due largely to teachers' lack of time, and "frustration" in having to respond to questions about change in the study child.

Changes in health classes are long overdue. Even for the teacher who has been adequately trained (which too few are), and is experienced and knowledgeable about handicapping conditions and their effect on children, it is difficult to teach different grades in one class. Structural changes in schools would permit a proportion of the children in health classes to be transferred to regular classes. Problems in obtaining evaluations of intellectual capacity are but one aspect of the "red tape" involved in this transfer. These can and should be overcome.

Will the Study Findings Stimulate Schools and Hospitals to Consider the Use of Community Centers As Resources In the Rehabilitation Of Physically Handicapped Children?

This final question included in the study has been answered for the schools, except to add that without time or special personnel to assume the responsibility implied in the question, the answer is "No". However, if, as has been indicated earlier in this chapter, group activity programs become available in or near the school, the answer would be in the affirmative. The answer so far as hospitals is concerned is more complicated, because they are not generally decentralized.

Responsibility of Hospitals in Utilizing Community Centers as Resources in the Rehabilitation Process.

Obviously hospitals and clinics for the orthopedically disabled need to include in their treatment plans, opportunities for the kind of activities the demonstration provided for the Experimental group of children. The problems encountered in the study would tend to make such referrals unrealistic unless centers move out into their neighborhoods. Hospitals can be of help in seeing that these children, a majority of whom in the Metropolitan New York area are either Negro or Puerto Rican on the basis of available statistics as well as the present study, obtain the best available medical care and follow-up, and in stimulating mothers to inquire about possible group-serving agencies in their school. Hospital Social Service Departments can do much to help parents view the handicap in a realistic perspective. The fact that many do not ask the questions they have buried for years does not mean they do not still need accurate information as to how birth defects of a wide variety occur, as well as their child's disability, through accidents. They can also help parents to view the child as normal in all other respects except for problems related to the disability. For this, time to talk with parents will be required. When emotional feelings are involved while listening to medical information and explanations, especially if complicated, these often need to be restated.

RECOMMENDATIONS

Replication

It is recommended that the study be replicated in another large city, taking into consideration the errors of omission and commission included in the text, to which should be added the following: separation of the demonstration from the evaluation created unnecessary difficulties. The evaluation needs to be viewed as an integral part of the demonstration. It would be important in including what was learned from this demonstration to emphasize the need to take into consideration today's racism in making placements as well as to provide opportunity for the parents to discuss their views openly in an educational, understanding atmosphere.

The Community Centers and Settlements.

A major problem for this and any study to be made in the near future was and continues to be the lack of a standard or norm by which to evaluate the benefits -- or the opposite -- of group activities for physically handicapped and "normal" children. This will require greater research awareness and interest as outlined earlier.

There is an urgent need for group work agencies to do what hospitals have begun to do in part, i.e., to decentralize and move out into the communities they are serving. If this is not possible, centers have a responsibility to stimulate the development of comparable and related facilities as discussed in the conclusions and implications, beginning with the public school system and its decentralized units. Because these centers have developed with a largely middle-class Jewish group, they seem to be out of touch with the needs of the different groups not now served -- in particular, families having physically handicapped children, a majority of whom are Negro and Puerto Rican. If they cannot relate to the changed communities, they have an obligation to share their expertise as they stimulate the development of more truly "neighborhood" group activity programs, in particular with the schools, as explained earlier.

Schools.

The public schools in a metropolitan area such as New York have a special obligation to provide superior education for all children, including the physically handicapped children all of whom -- if they are in health classes -- do not now obtain the same kind of education that is available in the regular classes. There is a need to compensate for the disability of these children, whether it be mobility which is common to most, or some other kind of handicap, by making the necessary structural changes in school buildings so that these children will not be segregated in the basement or some other part of school buildings, isolated from contact with the other school children. Without the structural changes and access to the best education available, their futures are endangered in a society that has become and continues to develop on an increasingly technical basis.

Since many of the children now in school have already been exposed to inferior education, (as has been indicated), it is recommended that the Self-Image Instrument be used instead of or in addition to some of the psychological testing to assess a child's ability to be in a regular class. What now prevents many, according to the most interested and dedicated teachers, from being in regular classes is the lack of ramps and elevators, and "red tape."

The somewhat extreme variation in the quality of teachers in health classes found in visits to 100 schools at three different times in a two-year period suggests the recommendation that training for teaching children with the variety of handicapping conditions with which children in health classes have to cope should be mandatory for all and the selection be on a basis of their special qualifications and training for this kind of teaching.

A final recommendation for schools, elaborated earlier, is the development of a variety of group activities to extend the opportunies for integration of the physically handicapped (and other handicapped children) in play, interest, musical, arts and crafts groups, etc., with the involvement of parents of these children as well as adults from the community in all its functioning. There are not enough community centers ready and willing to take the physically handicapped children and provide the necessary supportive services needed. The school is the only community institution that can play this kind of role in facilitating the necessary integration, not merely on behalf of the handicapped but also to socialize and humanize the so-called "normal" or non-handicapped.

Adult Education.

For parents of the physically handicapped the school today is the institution that can and should begin to provide health education beginning with an understanding of handicapping birth anomalies, etc. and continuing into health education on a far more comprehensive and preventive basis. Had this kind of health education been built into the school system with adults involved, sex education and drug education, particularly the latter would not be the step-children of the school curriculum with too few health educators able to communicate directly with students.

For Social Agencies Generally and Especially Those Providing Services for the Orthopedically Handicapped and Other Handicapped Children.

It is recommended that resources and manpower be pooled to make a survey of the status of services available versus services needed for handicapped children in light of the 1930 White House Conference Bill of Rights for Handicapped Children and the recent 1970 White House Conference on Children and Youth. This should prove to be a dramatic and realistic way to publicize the unmet needs of these children as well as bring about an association of the agencies and through them. to help the parents involved to form a single pressure group -- without which it appears resources are chronically in short supply.

BIBLIOGRAPHY

BIBLIOGRAPHY

Adams, Margaret. "Siblings of the Retarded: Their Problems and Treatment," *Child Welfare*, Vol. LXVI, June, 1967.

Ansbacher, Heinz L. and Rowena R. (eds.), *The Individual Pyschology of Alfred Adler*. New York: Basic Books, Inc. 1959.

Arundell, Ronald, et al. "Attitudes Towards the Handicapped-The Effect of Social Contact." Master's Thesis, Fordham University School of Social Work Service, New York, 1968.

Baldwin, Alfred L. *Theories of Child Development*. New York: John Wiley & Sons, Inc., 1968.

Barish, Herbert, et al. "Integration of Physically Handicapped Children Into Group Service Agencies." Master's Thesis, Columbia University School of Social Work, New York, 1961.

Barker, Roger G. "The Social Psychology of Physical Disability," *Journal of Social Issues*, Vol. IV, No. 4, Fall 1948.

____________. "Somatapsychological Significance of Crippling," *Adjustment to Physical Handicap and Disability*, New York: Social Science Research Council, 1953. (In collaboration with Beatrice Wright, Lee Myerson and Mollie R. Ganick.)

Barsch, Ray H. *The Parent of the Handicapped Child: The Study of Child-rearing Practices*. Springfield, Illinois: Charles C. Thomas, 1968.

Bellafatto, Carmen C., et al. "A Study of the Self-Image of Children in Foster Care." Master's Thesis, Adelphi University Graduate School of Social Work. Garden City, New York, June, 1968.

Board of Education, New York City. *The Committee for the Study of the Care and Education of Physically Handicapped Children in the Public School of the City of New York*, 1941.

Bonner, Hubert. *Psychology of Personality*. New York: Ronald Press Co., 1961.

Chandler, Caroline A. "Psychosocial Research Needs." National Institute of Mental Health, U.S. Department of Health, Education, and Welfare, Washington, D. C.

Cohen, Louis. "Level of Aspiration Behavior and Feelings of Adequacy and Self-Acceptance," *Journal of Abnormal and Social Psychology*, Vol. XLIX, January, 1954.

Cohn, Pauline C. "The Impact of the Handicapped Child in the Family," *Outlook*, January, 1964.

Cole, Minerva G. and Podell Lawrence. "Serving Handicapped Children in Group Programs," *Social Work*, Vol. 6, No. 1, January, 1961.

Conant, James. *Slums and Suburbs: A Commentary on Schools in Metropolitan Areas*. New York: McGraw-Hill Book Company, Inc., 1961.

Coughlin, Ellen W. "Some Parental Attitudes Toward Handicapped Children," *The Child*. U.S. Department of Labor, Children's Bureau, Vol. VI, No. 2, August, 1941.

Coven, Estelle W., et al. "A Study of the Self-Image of Children With an Orthopedically Handicapped Sibling." Master's Thesis, Adelphi University Graduate School of Social Work, Garden City, New York, June, 1968.

Cowen, Emory L. "The 'Negative Self Concept' as a Personality Measure," *Journal of Consulting Psychology*, Vol. 18, No. 2, April, 1954.

Cruickshank, William M. "The Relation of Physical Disability to Fear and Guilt Feelings," *Child Development*, Vol. XXII, December, 1951.

__________________. "A Study of the Relation of Physical Disability to Social Adjustment," *American Journal of Occupational Therapy*, Vol. VI, 1952.

__________________., (ed.). *Psychology of Exceptional Children and Youth*. New Jersey: Prentice-Hall, 1955.

__________________. "Psychological Considerations with Crippled Children," *Psychology of Exceptional Children and Youth*, ed. W. Cruickshank. Englewood Cliffs, N. J.: Prentice-Hall, 1963.

Deschin, Celia S. "How Can Social Work Make A Major Contribution To Psychiatric Theory?" *Journal of Psychiatric Social Work*, Vol. XX, No. 2, December, 1950.

________________. "Psychiatric Casework Interviewing as a Research Method in the Human Relations Field," *Journal of Psychiatric Social Work*, April, 1953.

________________. "The Relation of Socio Economic and Cultural Factors to an Understanding of Illness." *Dissertation Abstracts*, New York University, Vol. XIX, No. 8, 1958.

________________. "Research Interviewing in Sensitive Subject Areas: Some Further Applications and Suggested Principles," *Social Work, Journal of National Association of Social Workers*, New York, Vol. 8, No. 2, April, 1963.

________________. *Teenagers and Venereal Disease: A Sociological Study*. U.S. Department of Health, Education, and Welfare, Public Health Service, 1961.

________________. "Implications for Schools of a Demonstration Project to Integrate Orthopedically Handicapped Children in Community Centers with Their Non-Handicapped Peers." Presented at the scientific forum of the Research Council of the American School Health Association, Miami Beach, Florida, October 21, 1967. Mimeographed copy, prepared by New York Service for the Handicapped.

________________. "The Future Direction of Social Work - 1. From Concern with Problems to Emphasis on Prevention," American Journal of Orthopsychiatry, Vol. 38, No. 1, January, 1968.

________________. "The Need to Extend Medical Services Beyond the Hospital if Maternal and Infant Care Is to Become Comprehensive," American Journal of Public Health, Vol. 58, No. 7, July, 1968.

________________. "They Can Communicate: Self-Image Evaluation." Monograph I. Mimeographed copy, prepared by New York Service for the Handicapped, June, 1970.

________________. "Families In Trouble: A Comprehensive Family Rating Technique." Monograph II. Mimeographed copy, prepared by New York Service for the Handicapped, September, 1970.

Dick, Harry R., Ph.D. "The Measurement of Morale of Handicapped Children," Cerebral Palsy Review, Wichita, Kansas: Institute of Logopedics, Inc., November-December, 1964.

Dow, Thomas E., Jr. "Social Class and Reaction to Physical Disability," Psychological Reports, Vol. VII, January, 1965.

Downs, Hugh. "Role of the Citizen and of the Community in Mental Health," Mental Hygiene, Vol. 51, April, 1967.

Drover, Glenn G. Rehabilitation: A New Focus for Community Organization, Master's Thesis, Fordham University School of Social Work, New York City, 1965.

Egland, George O. "Treating 'C.P.'s' as Persons," Cerebral Palsy Review, Wichita, Kansas: Institute of Logopedics Inc., July-August, 1964.

Eisenstein, Fannie. "Life Enrichment of the Seriously Handicapped Through the Group Work Process," Social Work With Groups, New York: National Association of Social Work, 1959.

Ellsworth, Sterling G. "Building the Child's Self-Confidence," N.E.A. Journal, February, 1967.

Erikson, Erik. "The Problem of Ego Identity," Journal of the American Psychoanalytic Association, Vol. IV, 1956.

________. *Childhood and Society*. New York: W. W. Norton and Company, 1964.

Forte, Nelson. *Identity and Interpersonal Competence*. Chicago, Illinois: University of Chicago Press, 1955.

Friedenberg, Edgar Z. *The Vanishing Adolescent*, Beacon Hill, Boston: Beacon Press, 1960.

Garret, James P. (ed.) *Psychological Aspects of Physical Disability*, Office of Vocational Rehabilitation Service, Series #210, Department of Health, Education, and Welfare, Washington, D. C., 1960.

Gates, M. F. "Comparative Study of Some Problems of Social and Economic Adjustment of Crippled and Non-Crippled Boys and Girls," *Journal of Genetic Psychology*, Vol. 68, June, 1964.

Gellman, William. "Roots of Prejudice Against the Handicapped," *Journal of Rehabilitation*, Vol. XXV, No. 1, January-February, 1959.

Goady, Henry E., et al. "The Meaning of Integrated Group Participation to the Handicapped Child and His Family." Master's Thesis, Adelphi University Graduate School of Social Work, Garden City, New York, June, 1966.

Goodman, Norman, et al. "Variant Reactions to Physical Disabilities," *American Sociological Review*, Vol. 28, No. 3, June, 1963.

________. "The Adolescent With A Communication Impairment." Vol. 25, No. 2, February, 1964.

Graliker, Betty, Karol, Koch, and Richard Fishler. "Teenager Reaction to a Mentally Retarded Sibling," *American Journal of Mental Deficiency*, LXVI, May, 1962.

Guensberg, Marcus. "Emotional Implications of Handicaps," *Crippled Child*, National Society for Crippled Children and Adults, Chicago, Illinois, February, 1950.

Hall, William T. "Physical Handicap and Family Stress," *Cerebral Palsy Review*, Vol. XXIV, July-August, 1963.

Havighurst, Robert J. *Developmental Tasks and Education*. New York: Longmans, Green, 1951.

Henrich, Edith and Leonard Kriegal. *Experiments in Survival*. Association for the Aid of Crippled Children, New York, 1961.

Henry, Jules. *Culture Against Man*. New York: Random House, 1964.

Herman, Melvin. "Reintegration of Handicapped Persons into the Community," *Social Work With Groups*, National Association of Social Workers, 1961.

Herzog, Elizabeth. "How Much Are They Helped," Children, Vol. 5, No. 6, November-December, 1958.

_____________. "Research, Demonstration, and Common Sense," Child Welfare, June, 1962.

_____________. "Some Assumptions About the Poor," Social Service Review, Vol. 37, No. 4, December, 1963.

Herzog, Elizabeth and Cecelia E. Sudia. "Family Structure and Composition: Research Considerations," Reprinted with Permission from: Race, Research and Reason: Social Work Perspectives. New York: National Association of Social Workers, 1969.

Hollingshead, August B. Elmtown's Youth. New York: John Wiley and Sons, Inc., 1949.

Hollingshead, Merrill T. "The Social Psychology of Exceptional Children," Exceptional Children, Vol. 26, No. 1, September, 1959.

Holmes, Douglas. "A Study of the Problems of Integrating Physically Handicapped Children with Non-Handicapped Children in Recreational Groups." Children's Bureau Project (D-74). Final Report - Associated YM-YWHA's, New York, 1966.

Hurlock, Elizabeth B. Child Development. New York: McGraw-Hill, Inc., 1956.

Jacobsen, Margaret C., et al. "A Study of the Problems of the Severely Orthopedically Handicapped Child and His Family." Master's Thesis, Adelphi University Graduate School of Social Work, Garden City, New York, June, 1967.

Jacobson, Edith. The Self and the Object World. New York: International Universities Press, 1964.

Jahoda, Marie. Current Concepts of Positive Mental Health. New York: Basic Books, Inc., 1958.

Jersild, Arthur T. In Search of Self. New York: Teachers College, Columbia University, 1952.

Kadushin, Alfred, Joann, Sobel and Garry B. Rose. "The Relationship between Parents, Expressed Attitudes and Their Decisions," Social Casework, June, 1967.

Katz, Alfred H. Parents of the Handicapped. New York: Charles C. Thomas, 1961.

Kidd, Alpine, and Jeanne Revoire. Perceptual Development in Children. New York: International Universities Press, 1966.

Kiff, Aaron. "Front Door Citizens," The Crippled Child, Vol. XXXIII, No. 4, December, 1955.

Klineberg, Otto. "Desegregation and Integration," *The Social Welfare Forum*, New York: Columbia University Press, National Conference on Social Welfare, 1957.

Koenig, Frances G. "Social Consciousness in Relation to the Physically Handicapped." *Exceptional Children*, Vol. 15, No. 5, February, 1949.

Kolodney, Ralph L. and Virginia M. Burns. "Group Work With Physically and Emotionally Handicapped Children in a Summer Camp." *Social Work with Groups*, New York: National Conference on Social Welfare, 1958.

________________, et al. "The Neighborhood Peer Group," *The Group*, Vol. 17, No. 2, October, 1954.

________________. "Therapuetic Group Work With Handicapped Children." *Children*, May-June 1959.

Kouni, Jacob, Norman Polansky, and Edwin Thomas. "The Expected Behavior of a Potentially Helpful Person", Human Relations, Vol. 8, No. 2, 1955.

Lange, Patricia. "Frustration Reactions of Physically Handicapped Children," *Exceptional Children*, Vol. XXV, 1959.

Lemkau, Paul V. "The Influence of Handicapped Conditions on Child Development," *Children*, Vol. 8, No. 2, March-April, 1961.

Lepine, Louis, and Bernard Chordorkoff. "Goal Setting Behavior, Expressed Feelings of Adequacy and the Correspondence Between the Perceived and Ideal Self," *Journal of Clincial Psychology*, Vol. XI, October, 1955.

Levy, Charles S. "Disparities Between the Idealizations and Experience of Jewish Community Center Professional Personnel," Jounnal of Jewish Communal Service. Vol. XLV, No. 3, Spring, 1969.

Lewis, Harold. "The Use and Place of Research in the Administration of the Social Agency," Child Welfare, January, 1965.

Maas, Henry S. and Richard E. Engler, Jr. *Children in Need of Parents*. New York: Columbia University Press, 1959.

Maas, Henry S. (ed.) *Five Fields of Social Service: Reviews of Research.* New York: National Association of Social Workers, Inc., 1966.

Meier, Elizabeth G. "An Inquiry Into the Concepts of Ego Identity and Identity Diffusion," *Social Casework*, Vol. XLV, No. 2, February, 1964.

Menninger, W. C. "Emotional Adjustment for the Handicapped," *Crippled Children*, December, 1959.

Miller, Marian V. *A Study of the Attitudes of Intermediate Grade Children Toward Their Orthopedically Handicapped Peers.* Doctoral Thesis, Teachers' College, Columbia University, 1955.

Morgan, John S. "Research in Social Work: A Frame of Reference," *Social Work Journal*, October, 1949.

Mussen, P. and R. Barker. "Attitudes Toward Cripples," *Journal of Abnormal Psychology*, Vol. 39, No. 3, 1944.

Nash, Marygold V. *A Study of Attitudes of a Group of Non-Handicapped People Toward the Orthopedically Handicapped.* Doctoral Thesis, Columbia University School of Social Work, 1962.

National Institute of Mental Health. "The Teacher and Mental Health," U.S. Department of Health, Education, and Welfare, Public Health Service, National Institute of Health, Bethesda, Maryland.

New York State Youth Commission. "Outlook for the Handicapped," *A Decade of Progress.* Albany, New York: Committee for the 1960 White House Conference on Children and Youth, Vol. I. Prepared and edited by Dorothy Dunbar Bromley.

Norris, Miriam and Barbara Wallace, (eds.). *The Known and Unknown in Child Welfare Research: An Appraisal.* New York: National Association of Social Workers, 1965.

Plant, James S. *Personality and the Cultural Pattern.* New York: The Commonwealth Fund, 1937.

________. *The Envelope.* Cambridge, Massachusetts: Harvard University Press, 1958.

Plutarch. *Plutarch's Lives.* Translated by John Dryden in 1683. Revised by Arthur Hugh Clough in 1859. Chicago, Illinois: Great Books Foundation, Reprinted in 1955.

Pumphrey, Ralph E. and W. Muriel (eds.). *The Heritage of American Social Work.* New York: Columbia University Press, 1961.

Rapoport, Lydia and Kate S. Dorst. "Teamwork in a Rehabilitation Setting: A Case Illustration" *Social Casework*, Vol. XLI, No. 6, June 1960.

Redl, Fritz. *When We Deal With Children.* New York: The Free Press, 1966.

Richardson, Stephen, et al. "Cultural Uniformity in Reaction to Physical Disabilities," *American Sociological Review*, Vol. 26, No. 2, April 1961.

________________. "Variant Reactions to Physical Disabilities," *American Sociological Review*, Vol. XXVIII, June, 1963.

________________________. "Effects of Physical Disability on a Child's Description of Himself," Child Development, Vol. 35, No. 3, September, 1964.

Roberts, Dean W., et al. "Physically Handicapped," Social Work Yearbook, New York: National Association of Social Work, 1960.

Robbins, Harold W. "Priorities, Goals and Values - A Neighborhood Center Dilemma." Paper presented at the National Conference of Social Welfare, Dallas, Texas, May 1967.

Robbins, Harold W. and Regina Schattaner. "Obstacles in the Social Integration of Orthopedically Handicapped Children, Journal of Jewish Communal Services, Vol. XLV, No. 2, Winter, 1968.

Roeher, G. Allan. "Significance of Public Attitudes in the Rehabilitation of the Disabled," Rehabilitation Literature, Chicago, Illinois: National Society for Crippled Children and Adults, Vol. 22, No. 3, March, 1961.

Ross, Helen. "The Handicapped Child and His Family," Crippled Child, Chicago, Illinois: National Society for Crippled Children and Adults, February, 1953.

Ross, Myra M. A Study of Self Concept and Some Thoughts for Measuring It. Master's Thesis, Graduate Faculty, Western Connecticut State College, 1968.

Sanford, Nevitt. Self and Society. New York: Atherton Press, 1966.

Sarnoff, Irving. Personality Dynamics and Development. New York: John Wiley and Sons, 1962.

Saunders, Lyle. Cultural Difference and Medical Care. New York: Russell Sage Foundation, 1954.

Schechter, Marshall D. "The Orthopedically Handicapped Child: Emotional Reaction," Archives of General Psychiatry, Vol. IV., 1961.

Schilder, P. The Image and Appearance of the Human Body, New York: International University Press, 1950.

Schwartz, Arthur and Marvin Lieberman. "Integrating the Orthopedically Handicapped Child Into the Center," Jewish Community Center Program Aids, Summer, 1963.

Schwartz, Arthur. Social Recreational Patterns or Orthopedically Handicapped Children. Associated YM-YWHA's of Greater New York, July, 1962.

Shotland, Leonard. "Social Work Approach to the Chronically Handicapped and Their Families," Social Work, Vol. 9, No. 4, October, 1964.

Sherif, Muzafer, and Hadley Cantril. *The Psychology of Ego-Involvement: Social Attitudes and Identifications.* New York: John Wiley and Sons, Inc., 1947.

Somers, Bernard Joseph. *Displaced Hostility in Physically Handicapped Subjects.* New York: Teacher College, Columbia University, 1958.

Steven, Hazel. "Difficulties in Group Adjustment Encountered by the Physically Handicapped," *Crippled Child*, Vol. 22, No. 5, February, 1946.

Suchman, Edward A. "A Model for Research and Evaluation on Rehabilitation," *Sociology and Rehabilitation*. Marvin B. Sussman, Ed., December, 1965.

Sussman, Marvin B., (ed.) *Sociology and Rehabilitation.* Cleveland, Ohio: American Sociological Association. Western Reserve University, 1965.

Swift, Joan. "Effects of Early Group Experience: The Nursery School and Day Nursery," *Review of Child Development Research.* Martin L. Hoffman and Lois W. Hoffman, eds. New York: Russell Sage Foundation, 1964.

Tenny, John W. "The Minority Status of the Handicapped," *Exceptional Children*, Vol. 19, No. 7, April 1953

Tobin, Richard L. "Not According to the Appearance," *Saturday Review*, February 26, 1966.

Von Frieandt, Kai. *The Role of Perception*. Homewood, Illinois: The Dorsey Press, 1966.

Von Hentig, Hans. "Physical Disability, Mental Conflict and Social Crisis," *Journal of Social Issues.* Vol. IV, No. 4, Fall, 1948.

Wallace, Helen M. "The Role of the Social Worker in the Rehabilitation of the Handicapped," *Social Casework*, Vol. XXXVIII, No. 1, January, 1957.

Weinstein, Eugene. *The Self-Image of the Foster Child.* New York: Russell Sage Foundation, 1960.

Wheelis, Allen. *The Quest for Identity*. New York: W. W. Norton & Company, Inc., 1958.

White, Esther. "The Body Image in Rehabilitating Severely Handicapped Patients," *Social Work*, Vol. 6, No. 3, July, 1961.

Witmer, Helen and Ruth Kitinsky, (eds.) "Personality in the Making." The Fact-Finding Report of the Midcentury White House Conference on Children and Youth. New York: Harper & Bros., 1950.

Witmer, Helen L., et al. Independent Adoptions - A Follow-up Study. New York: Russell Sage Foundation, 1963.

Wright, Beatrice A. Physical Disability - A Psychological Approach. New York: Harper and Row, 1960

Wylie, Ruth C. The Self-Concept: A Critical Survey of Pertinent Research Literature. Nebraska: University of Nebraska Press, 1967.

Yarrow, Marian Radke, et al. Child Rearing - An Inquiry Into Research and Methods. San Francisco, California: Bass Inc., 1968.

Young, Howard D. and Marygold V. Nash. Independent Living: A Study of Rehabilitation of Physically Handicapped Adults Living in Foster Homes. Report to the Vocational Rehabilitation Administration, 1966.

Yuker, Harold, Ph.D. "Attitudes as Determinants of Behavior," Journal of Rehabilitation, National Rehabilitation Association, Vol. XXXI, No. 6, November-December, 1965.

APPENDIX

INTERVIEW WITH PARENTS

Case #________

Surname________________________

Interviewer____________________ Length of time of interview___
Date________________

Agreement signed (date)___________ Refused to sign____________

Agreement to be sent (date)_______ Date received______________

Control ( ) Experimental ( ) Ineligible ( )

Name of center______________________________ Date started______

Contact dates

With family	With child		With Center

*Given before population was divided into experimental and control groups.

New York Service for the
Handicapped
Children's Integration Project
July 1965

Name of child____________________ Sex: M F Case #__________

Person interviewed: Fa ( ) Mo ( ) Child ( ) Age at which handicapped: __________

Interviewed first: Fa ( ) Mo ( ) Child ( ) Congenital__________

FAMILY COMPOSITION

FM#	Name	Sex	Relationship to head	Date of Birth	Yrs. of Sch.	Occup.or Sch.Grade 9/65	Out of home	
							Where	When
1		M	Male head					
2		F	Female "					
3								
4								
5								
6								
7								
8								
9								
10								

Other persons of significance to handicapped child not living in home

#	Name	Sex	Age	Comments on their role - negative or positive
11				
12				
13				
14				

List oldest to youngest children and star(*) handicapped child. If in school, give name of school and indicate whether in health or regular class; also grade as of September 1965. For others indicate last grade completed.

Relationship Code:

1 = Child of this marriage (indicate if adopted)
2 = Child of female head
3 = Child of male head
4 = Illegitimate child of female head
5 = Illegitimate child of male head
6 = Other relative, specify
7 = Other, specify (such as, roomer, foster child)

Case #__________

Medical diagnosis______________________________________

______________________________ Date of Diagnosis__________

Description of physical disability________________________

____

____

Limitations of the child's functioning____________________

____

____

FAMILY CHARACTERISTICS

Marital status		Fath(FM#1	Mother(FM#2	Housing
Mar( ) Wid ( )	Ethnic			Owns______
CL ( ) Des ( )	Birthplace			Rents______
Sep( ) Sing( )	Religion			Project______
Div( )	Gross earnings			Nonproj______

Address__________________ Time here______ Number of moves during life of child__________

Primary language spoken in home__________________________

TYPE OF HOUSING

IMPRESSION

1 family	____	Number of rooms	____
2 family	____	Number of bedrooms .	____
Apartment	____	Child has own room .	____
Furnished Room	____	shares room .	____
Tenement	____	shares bed ..	____

FAMILY INCOME - annual gross

Source	Amount	FM#
Earnings ...		
Absent parent		
Soc. Security		
OASDI		
Pension		
Welfare......		
Other______		

Case #____

INSTRUCTION: Wherever asterisk(*) appears, reference is to the handicapped child to whom you should refer by name when feasible.

1. Has *________ ever been away from home, except for a short visit to relatives, grandparents, or friends?
Yes ( ) No ( )

If yes, where	When	For how long?

Include here: Camps for the handicapped, special institutions, hospitals

If ever in a hospital, was continued treatment of an extensive nature on an outpatient basis, required? Specify type of treatment, frequency, and length of time treatment continued:

____

____

____

2. What kinds of special problems do you have regarding *________'s medical care? (For example, visiting doctors or places for care)

____

____

Specify type of treatment______________________

Length of time involved in treatment______________

Is any additional treatment planned (for example, surgery)?

____

When?______________________________

3. a. How does *________ feel about the medical treatments?______

____

____

b. What does *________ say about this?______________

____

Case #________

INSTRUCTION: The intent of questions 4 and 5 is to assess the overall attitude of the parents regarding the handicapped child as a basis for evaluating their handling of this child. Wait for responses before you use any probes. Indicate FM# of person answering questions.

4. How do you feel about *__________'s handicap?

5. a. What was your reaction when you first learned of *_________'s handicap?

   b. What changes did this make in your life?

6. a. How does *_________ feel about the handicap?

   b. How does he feel about looking different?

   c. How does he feel about not being able to do things other children do?

   d. Has he expressed any other feelings or attitude?

Case #_______

7. Does caring for *__________ make problems for you in the home?

Yes ( ) No ( ) If yes, what kind of problems?_____________

8. Do you or any other members of the family have health problems or handicaps?

Yes ( ) No ( ) Specify_____________________________

NOTE: Observe any indications of poor health in appearance or behavior of any member of the family_____________________

9. a. What kinds of chores do you give your other children?_________

b. What kinds of responsibilities for the care of *__________ do you give to the other children?_____________________

(Probes: help with dressing; with feeding; taking out to playground; babysitting)

c. What kinds of chores around the house do you give *__________?

What does *_________ do to take care of younger siblings?

d. Usually children do not like taking care of their brothers and sisters. How does *__________ feel about:

Being cared for by siblings?___________________________

Having to take some responsibility for siblings? ____________

Case #______

10. a. How do the siblings feel about their handicapped sibling?

b. What does *__________ do with siblings?

11. What about friends and playmates of your children (check)

	Siblings			*
FM#-				
a. Younger				
b. Older				
c. Same age				
d. Own Sex				
e. Other sex				
f. Handicapped. . .				
g. From neighborhood				
h. Other				

Comments:

Case #_________

INSTRUCTION: The intent of questions 12 and 13 is to get the range of interests and activities of all the children as well as of the study child as a basis for comparison and as another dimension of the family's cultural level. The questions are open-ended; if probes are necessary this should be indicated. The play activity of children provides significant clues to the child-rearing to which they have been exposed, as well as to their potential.

---

12. What are the interests and activities of your children?

Siblings	*

Comments (indicate whether FM#1 or FM#2)____________

13. a. How much time do your children spend watching TV?

	Siblings	*
Daytime		
Evenings		
Alone		
With others		

b. What are your children's favorite programs?

Siblings	*

Case #________

INSTRUCTION: Questions 14, 15, 16, and 17 are designed to obtain objective data regarding parental handling of the child under different conditions and in different situations. Indicate by FM# person giving answers. Use no probes. This is important for comparability. Otherwise responses may be suggested. More important than obtaining an immediate or full response in this interview is that parents be stimulated to think about this and feel sufficiently comfortable with the interviewer to be honest. Persons skillfully interviewed often state they are surprised at their "frankness." Be patient during silence. It may be the first time they have been asked these questions

---

Introduction to questions: Naturally, children with handicaps are treated somewhat differently than other children.

14. In what ways are you apt to treat *________ differently from the way you treat your other children? (If no siblings, word question as:

In what ways are you apt to treat *________ differently from the way you might treat a child of yours who was not handicapped?

____

____

____

____

15. a. If *____________ got hold of a toy you were not sure he knew how to play with what would you be likely to do? ______________

____

____

Give reasons: ________________________________

____

____

b. Would you act differently for another child of about the same age?

Yes ( ) No ( ) Why? ________________________

____

____

Case #________

Introduction to question: Most parents get angry with children when they get in the way or are misbehaving. This is as true of handicapped as of other children who do not have an orthopedic handicap. After all, in many respects *________ is just like other children.

16. a. When any of your children misbehave, how do you punish them?

b. If *__________ misbehaves, what is the punishment?__________

17. a. Is your neighborhood one that is safe for children to play out of doors near your house?

Yes ( ) No ( ) Reasons ____________________

b. Suppose *_________ is playing out of doors, would you:

i. Make him stay in own area where you can watch him?

Yes ( ) No ( ) Reasons ____________________

ii. Let go to a playground alone?

Yes ( ) No ( ) Reasons ____________________

iii. Let go away from neighborhood only if with another child?

Yes ( ) No ( ) Reasons ____________________

Case #__________

18. How does *______________ react to his handicap:

a. Forgets it when he is doing things he enjoys?

Yes ( ) No ( ) Describe______________________________

____

____

b. Knocks himself out trying to prove he can do things he really can't do?

Yes ( ) No ( ) Describe______________________________

____

____

c. Does *_________ use handicap to take advantage of playmates or siblings?

Yes ( ) No ( ) Describe______________________________

____

____

d. Can you think of times when you forgot *_________ was handicapped?

Yes ( ) No ( ) Can you remember what *_________

was doing at that time?______________________________

____

19. Many children have had some opportunity to be at a camp or recreation center with other children, handicapped and non-handicapped. How about your children - have they had such an opportunity?

	Siblings	*_______________
	Yes ( ) No ( )	Yes ( ) No ( )
Where?	______________	______________
	______________	______________
When?	______________	______________
Describe	______________	______________

____

Comments:______________________________________

____

____

Case #__________

Introduction to question: Handicapped children like normal children are all different and have different kinds of abilities --

20. a. Have you noticed any special talents or capabilities in *__________?

Yes ( ) No ( ) Can you tell me about this? __________

b. Special talents in your older children?

Yes ( ) No ( ) Describe __________

c. Can you tell me how *__________ behaves in school? __________

How does *________ get along with other children? __________

How does *________ do in school work? __________

d. What does the teacher say about *________? __________

21. What are your future plans for your children?

Siblings	*
a. For education __________	__________
b. For work __________	__________

22. What would you like your children to be when they grow up?

Siblings	*
__________	__________

Case #_______

23. If someone were to ask you to describe *______ as a person, what would you say?____

How do you feel about *______ as a person?____________________

24. What about yourself (indicate FM# of person answering)

a. What are your special interests?________________________

b. What are your plans for the future?________________________

25. Have you ever talked over some of the things we have just dissussed with someone like myself?

Yes ( ) No ( ) Where and When?________________________

In what ways was it helpful?________________________

26. I have asked you a lot of questions. What would you like to ask me?

27. Is there anything else you think our agency should know about *________ at this time?________________________

Case #__________

INTERVIEW WITH STUDY CHILD*

1. When did you first go to school?____________________

   Where?____________________________________

2. a. How did you feel when you first went to school?__________

   b. How do you feel about going back to school after the summer?

   c. How did you feel about school last year?____________

3. a. How do you feel about your class?________________

   Is this a health class? Yes ( ) No ( )

   b. Are there other handicapped children in your class?________

   c. Can you tell me whether they are more handicapped than you are?

   Less handicapped than you are?____________________

   Describe a few of them__________________________

---

*To prepare child for interview, give him some paper and crayon and ask him to draw a picture about his experiences at the center, or if he prefers, about his school or neighborhood. Allow sufficient time before moving into the interview.

Case #____________

4. What would you like to do right how, if you could have your wish come true? ____

____

____

5. What kind of children do you like to play with?

Age______ Sex________ Handicapped_______ Non-handicapped____

6. What kind of children do you play with most of the time?

Age______ Sex________Handicapped________ Non-handicapped____

7. Where do you play?____

8. What games do you play?____

____

9. When you are in the house, do you watch television a lot?

Yes ( ) No ( ) How often?____________________________

Can you tell me about your favorite programs?____________________

____

10. Do you have any close friends or buddies you can talk to whom you like best?

Yes ( ) No ( ) Describe____________________________

____

____

____

____

11. If you had three wishes, what would you wish for?____________

____

____

____

____

Case #__________

12. Are there times when you are home that you forget that you have a handicap?

Yes ( ) No ( ) Can you tell me when you feel this way?

____

____

____

Are there times when you are out of doors in your neighborhood when you feel this same way?

Yes ( ) No ( ) Can you tell me when you feel this way?

____

____

____

13. Who would you most like to be like?

First choice ______________________________

Second choice ______________________________

14. What would you most like to be when you grow up?

First choice ______________________________

Second choice ______________________________

15. How far would you like to go in shcool?______________

Why?______________________________

____

16. What do you like to read?______________________________

____

17. What things do you like to spend most of your time doing?______

____

____

____

18. What things do your friends and siblings most like to do?______

____

____

____

Case #__________

INSTRUCTION: The following are items taken from a sentence completion test that has been used with handicapped children. The numbers (#) refer to the numbers in that test since only those that seem appropriate for the initial interview have been selected. It is tentatively planned to give the entire test to all the children at a later date -- in the centers for the experimental group; in the home or at school for the control group. If the child can read and write, let him fill in this page.

---

19. We want you to finish these sentences in your own words:

a. (1) Most of all, I want to______________________________

b. (3) I would like to forget the time I______________________________

c. (6) If people would only______________________________

d. (7) I know I could do anything if ______________________________

e.(11) I could be happy if______________________________

f.(21) Other school children______________________________

g.(23) People who have trouble walking ______________________________

h.(26) If I weren't held back by______________________________

i.(29) I am worried about ______________________________

j.(30) No matter how hard I try, I ______________________________

k.(31) I like to be treated ______________________________

20. I have asked you a lot of questions -- what would you like to ask me?______________________________

Case #________

OBSERVATIONS AND IMPRESSIONS

Observations of child

Interaction between child and parent during child interview__________

____

____

In responding to questions, did child look to parent for approval and/or assistance?

Yes ( ) No ( ) Comment____________________

____

Did child rely on the interviewer for help and/or assistance?

Yes ( ) No ( ) Comment____________________

____

Impressions of child

Behavior during interview____________________

____

____

Type of child______ ____________________

____

Intellectual level of child____________________

Other comments____________________

____

____

____

____

____

Case #__________

Observations of the home

Physical condition of home (standards of housekeeping)

Excellent ( ) Good ( ) Fair ( ) Poor ( ) Very poor ( )

Atmosphere of home: Interactions:

Of children among themselves______________________________

Of children and parents______________________________

Of handicapped child with siblings______________________________

Of handicapped child with parents ______________________________

Conditions under which interview took place (for example, presence of some or all children; frequency and kind of interruptions).

____

Impressions of parents (Indicate FM#1 or FM#2, or both)

Interest in interview______________________________

Comprehension of questions ______________________________

Physical condition: Generally______________________________

Teeth______________________________

General appearance and manner: Energetic ( ) Listless( )

Complaining ( ) Comment:______________________________

Other comments:______________________________

TEACHER INTERVIEW I*

1. How long have you known ____________ (Name)

2. How long has he been in this class ____________

3. What is your impression of ____________ (Name)

4. a) (If child known for longer than one term) Can you recall how he first impressed you? ____________

   b) Any changes, specify ____________

   c) How do you account for this? ____________

5. Can you tell me something about ____________ (Name) handicap? ____________.

   b) How does it effect his academic performance? ____________

   c) Other activities? ____________

CHILD'S FUNCTIONING

Academic

6. How does ____________ (Name) do academically? ____________

7. What criteria do you use to assess the children academically? (e.g. report cards, marks, evaluation?) ____________

   (If in Health Class) Are the same criteria used for regular class? Yes ( ) No ( ) If "No", explain ____________

8. Could you describe his class participation - nature and extent. (e.g. does he volunteer or only answer if called on) ____________.

9. Do you think he lives up to his potential? ____________

10. What are his special talents or abilities? ____________

---

*In the interest of saving space here only one line is left blank for the answers that might take several lines in the actual interview.

11. How does he compare with the other students? (... of comparable age and type of handicap)______________________________

Academically?____

Socially?____

Physically Examination

12. a) What are the procedures for physical examination?_________

b) Does________________ (Name) receive any special therapy in the school? Specify____

13. If someone were to ask you to describe________________________ (Name) as a person, what would you say? (personality and emotional traits?)____

14. a) How does he get along with other children?________________

Can you be more specific or give an example?_________________

b) Has he made any friends? Specify__________________________

c) What do the other children think about him? (Leader, follower, etc.)____

Play Activities in Class

15. What are his play activities? (Name games)____________________

Isolated?_________________________________

With others?_______________________________

Prefers playing alone?___________________

If In Health Or Orthopedic Class

16. 1) Do the children in your class have a chance to be with non-handicapped children? Specify__________________________

If so, does he play with any non-handicapped children?

Specify____

2) Do you think ____________________ (Name) belongs in the class.

Yes ( ) No ( ) If not, what is the procedure for having him reassigned?____

How long does this procedure usually take?____________________

If In Regular Class

16. a) Does ______________________ have any contact with other
(Name)
handicapped children? Specify (in same class, other class)

____

If so, does he play with mostly handicapped children?________

Non-handicapped?____

17. In what ways are you apt to handle ____________________________
(Name)
differently than you would a non-handicapped child of comparable age?____

Relationship With Teacher

18. a) We are interested in knowing more about how______________
(Name)
relates to adults, as an example, can you tell me how ______________________ relates to you (obedient, re-
(Name)
bellious, withdrawn and unresponsive, relates appropriately, etc.)____

b) How does ___________________ accept directions, classroom
(Name)
routine and discipline?_____________________________________

c) Does he require more individual or specialized attention than the others, specify___________________________________

Parent Contact With School

19. What contacts do the parents have with you?

a) With teacher?_______________

1. Open School Week?_____________________
2. Individual Conference?________________
(Who initiates?)__________________________
3. Any volunteer activity on part of parent? Specify____

____

b) Contacts with school?
1. P.T.A.________________________
2. Other__________________________

INTERVIEWER'S OBSERVATIONS AND IMPRESSIONS

Place and circumstances of interview ________________________

Attitude of teacher toward teaching handicapped children and observation of teacher's handling of children (stereotypes (?), objective basis for these observations, list.) ________________

____

Attitude of teacher toward participation in interview and toward New York Service Project ____________________________

Character of teacher's relationship to child ________________

____

Description of school and classroom ________________________

____

TEACHER INTERVIEW II & III

1. How long have you known *____________? ______________

2. a) Do you think he belongs in this class? Yes ( ) No ( )

   b) If no, what class do you recommend and why?____________

3. a) Can you tell us how *__________ does academically in comparison to the other class members?______________

   b) (Ask only of Health Class Teachers) How does *________ compare to other children in his age group?___________

4. a) Do you think he lives up to his potential? Yes( ) No ( )

   b) Explain and, if possible, give illustration:____________

   ____

5. What are *__________'s special talents or skills?

   a) Has ( ) Hasn't ( )

   b) Specify____

   c) If a new skill, where did he learn this?____________

6. a) How does *________ get along with the other children in his class?______________________________

   b) What friends has he made in his class?______________

   c) What do the other children think of him?____________

   d) How does *________ compare socially to his classmates?

   ____

7. Can you tell us what changes you have observed in *________'s academic and social functioning since the beginning of this year?____

   (If known less than a year, since you have known him.)________

   ____

8. Do you feel that *________ will be able to go on to High School? Yes ( ) No ( ) Explain______________

9. In what ways are you apt to handle *________ differently than you would a non-handicapped child of comparable age? ________

   ____

10. a) We are interested in knowing about how *__________ relates to adults; as an example, can you tell us how *__________ relates to you?____________________

b) How does *__________accept direction, classroom routine and discipline?____________________

11. a) What contacts do the parents have with you?

( ) Open School Week ( ) PTA

( ) Individual Conference ( ) Other__________

b) If there has been no contact by the parents, what do you know about the family that might account for this?

____

12. EXPERIMENTAL CHILDREN

Introduction: We are interested in knowing how children are affected by extra-curricular experiences such as scouts, clubs, community centers, etc.

a) In what ways do you think *__________ has been affected by his after-school experience?____________________

b) What has *__________ told you about the experience?

____

c) Do you know of any other children in your class who do participate in such activities? Yes ( ) No ( )

d) If yes, have you observed any changes in these children which you feel might be attributed to the experience? (e.g., new or more developed skills, changes in social relationships.)

____

12. CONTROL CHILDREN

Introduction: We are interested in knowing how children are affected by extra-curricular experiences such as scouts, clubs, community centers, etc.

a. Do you know of any children in your class who do participate in such activities? Yes ( ) No ( )

b) If yes, have you observed any changes in these children which you feel might be attributed to the experience? (e.g., new or more developed skills, changes in social relationships.)

____

c) Does our study child participate in any after-school recreational programs? Yes ( ) No ( )

d) If yes, specify______________________________

e) In what ways do you think he has been affected by this after-school experience?____________________

____

13. TO BE ASKED OF HEALTH CLASS TEACHERS ONLY

a) How did you happen to become a Health Class teacher?

____

b) How long have you been teaching Health Classes? __________

c) In what ways do you find teaching handicapped children different from teaching children in regular class?

____

14. a) If you wanted to refer a handicapped child with a behavior or personality problem, what procedure would you follow?____________________________

b) Do you feel that *__________ or any other handicapped child in your class is in need of such help?

Yes ( ) No ( )

Interviewers: Describe NYSOH Family Counseling Service; give agency cards, if indicated.

INTERVIEWER'S OBSERVATIONS AND IMPRESSIONS

Attitude of teacher toward teaching handicapped children and observation of teacher's handling of children (stereotypes (?), objective basis for these observations, list):

____

Character of teacher's relationship to child:____________________

____

Attitude of teacher toward participation in interview and toward New York Service Project:

____

____

C H A R T II

CENTER RATING CHART*

Name of Center ________ Borough ________ Month of ________

Form Completed by ________

	Excellent	Good	Fair	Poor or None	Score (For Office Use Only)
1. Physical Facilities					
2. Readiness to do own casefinding					
3. Initiates and/or maintains contacts with hospital and schools					
4. Accepts consultant role of project staff					
5. Readiness to provide scholarships for orthopedically handicapped child					
6. Cooperation re: research and administrative requirements					
7. Supervision of group leaders					
8. Ability of group leaders					
9. Club and/or small group program					
10. Follows-up on absentees and droupouts					
11. Attitude of Executive Director					
12. Attitude of Junior Supervisor					
13. Group leaders attitude					
14. Parent involvement					
15. Maintains attendance records					
16. Involvement of Board of Directors					
17. Sees orthopedically handicapped child as their client					
18. Provides casework or makes referrals					
19. Attitude about field workers visits					
20. Readiness to have project staff participate in staff meetings					
21. Attitude toward accepting a realistic number of orthopedically handicapped children					
22. Attitude toward serving atypical children					
23. Administrative operation					
24. Publicizes project in centers publicity media					
25. Basic commitment to social values					

---

*Developed by Harold W. Robbins

GROUP LEADER'S EVALUATION OF ORTHOPEDICALLY HANDICAPPED CHILD

______________________ (Name of Child)	______________________ (Center)
______________________ (Group Leader)	______________________ (Date)

Instructions:

We would appreciate your help in completing the attached form which concerns your contact with *______________________. This child is participating in our demonstration project to integrate handicapped children with the non-handicapped in after-school programs.

If your contact with the child has been limited, please complete as many of the questions as you can.

Your cooperation in helping us to assess the effectiveness of our project is greatly appreciated. If will contribute to the development of improved services for the handicapped.

I. GROUP

Type of Group

1. Club ______________ Special Interest (Specify)__________

____

Other (specify)______________________________

2. How many times a week does (did) group meet?__________

3. How many times a week do (did) you meet with group?______

4. Number of group members?________________________

5. Average attendance at meetings (approx.)______________

6. Religious composition of group:

	Cath.	Prot.	Jewish	Other
M				
F				

7. Ethnic composition of group:

	Negro	White	P.R.	Other
M				
F				

8. Total number of orthopedically handicapped in group______

9. Age range of group ______________________________

10. How does (did) child's age compare with majority of group? Older ( ) Younger ( ) Same ( )

11. Were you given any prior orientation regarding admission of handicapped child? Yes ( ) No ( )

If yes, describe________________________________

12. Was the group prepared for admission of handicapped child? Yes ( ) No ( )

If yes, describe________________________________

13. How long have you known the child? ______________

II. CHILD

Attendance

1. Approximate date of child's entrance into group__________

2. Child's attendance is (was): Good ( ) Fair ( ) Poor ( )

3. How does (did) the child's attenace compare with that of others:

a) Handicapped children? Better ( ) Same ( ) Worse ( )

Comments____

b) Non-handicapped children?
Better ( ) Same ( ) Worse ( )

Comments ____

Activity Participation

1. Does (did) the child participate in most activities?

In the beginning:	When last observed:
Yes ( ) No ( )	Yes ( ) No ( )

Comments:____

2. What was the child's attitude toward participation in activities?

In the beginning:		When last observed:	
Eager and enthusiastic	( )	Eager and enthusiastic	( )
Moderately interested	( )	Moderately interested	( )
Needed encouragement	( )	Needed encouragement	( )
Generally refused to participate	( )	Generally refused to participate	( )
Other, specify____________		Other, specify____________	

3. Which activities does (did) the child prefer? (Check one of each pair)

a) In the beginning:

Active games	( )	Individual activities	( )
Quiet games	( )	Group activities	( )
Arts & Crafts	( )	Athletics	( )

Other (specify________________________________

____

b) When last observed:

Active games ( )
Quiet games ( )
Individual activities ( )
Group Activities ( )
Arts & Crafts ( )
Athletics ( )
Other, specify____________________

4. Does (did) the child seem to enjoy himself in the group?

Usually ( ) Sometimes ( ) Never ( )
Comments:____________________

5. How does (did) his ability in the group compare to:

a) Other handicapped children's ability
Same ( ) Different ( )
If different, specify____________________

b) Non-handicapped children's ability
Same ( ) Different ( )
If different, specify____________________

6. Does(did) the child learn any new skills in the group?
Specify____________________

7. Does (did) you have to make any modifications to accommodate the child's handicap? Yes ( ) No ( )
If yes, specify____________________

8. What were the attitudes of the group as a whole toward the handicapped child?

In the beginning: Acceptance ( ) Indifference ( )
Avoidance ( ) If other, specify____________________

9. How were these attitudes shown?

In the beginning:		When last observed:	
By seeking him out	( )	By seeking him out	( )
By assisting him	( )	By assisting him	( )
By refusing to help	( )	By refusing to help	( )
Other, specify________		Other, specify________	

Peer Relationship

1. How did the child get along with other children in the group?

In the beginning:		When last observed:	
Well	( )	Well	( )
Poorly	( )	Poorly	( )
Moderately well	( )	Moderately well	( )

2. Does (did) he make any friends? Yes ( ) No ( )
If no friends, why?____________________________________

3. Who initiated any friendships he has (had)?
The child, himself ( )
Other handicapped children ( )
Non-handicapped children ( )

4. How do (did) the other children react to him?__________
____

5. a) How does (did) he compare socially with non-handicapped children in the group?

More sociable ( )
About the same ( )
Less sociable ( )

b) How does (did) he compare with other handicapped children?

6. Do (did) the other group members ask about his handicap?

Yes ( ) No ( ) If yes, give details________________

Relationship to Leader

1. In what ways are (were) you apt to handle *____________ differently than a non-handicapped child of comparable age? ____

2. How does (did) he relate to you? Check appropriate word(s)

In the beginning:	Sometimes	Always	Never
Responsive	( )	( )	( )
Rebellious	( )	( )	( )
Friendly	( )	( )	( )
Dependent	( )	( )	( )
Withdrawn	( )	( )	( )
Compliant	( )	( )	( )
Hostile	( )	( )	( )
When last observed:			
Responsive	( )	( )	( )
Rebellious	( )	( )	( )
Friendly	( )	( )	( )
Dependent	( )	( )	( )
Withdrawn	( )	( )	( )
Compliant	( )	( )	( )
Hostile	( )	( )	( )

Overall Assessment

1. What three words would you use to describe the child?

   ____________ ____________ ____________

2. If someone were to ask you to describe the child as a person, what would you say? ____________

3. Has (did) the child's social functioning shown any change since he joined the group? Yes ( ) No ( )
   Specify____________

4. Does (did) the child have any special talents? Yes ( )
   No ( )

5. Describe how the child reacts (reacted) to his handicap.

   ____

   ____

6. Does (did) he ever talk about his handicap? Yes ( )
   No ( )
   Describe____________

7. In what ways does (did) the child perceive himself differently now than when he began in the group?
   Specify____________

   ____

PLACEMENT COUNSELOR'S OBSERVATION OF STUDY CHILD IN EACH GROUP

Dated_______________

Child__________________________ Borough Director _______________

Center _________________________ Date of Child's Entrance_________

Date(s) of Observation______________________________________

(NOTE: FOR EACH OF THE ITEMS BELOW, INDICATE THE CHILD'S INITIAL REACTION, AND SHOW PROCESS OF ANY DEVELOPMENT OR CHANGE.)

I. Description of group and/or activity (e.g., kind of group, name of group, number of children, day group meets.)

____

____

II. Relationship with leader (Initial and current if changed)

1. What is the leader's attitude toward child?___________

____

2. What is the child's attitude toward leader?___________

____

3. How does child's attitude compare with that of the majority of non-handicapped in the group? Of other handicapped? _______________________________

____

III. Activity Participation (Initial and current if changed)

1. Describe nature and extent of child's participation. (e.g., amount of interest, prefers isolated play, plays with others spontaneously, needs encouragement or other kinds of help from leader or other group members).

____

____

____

2. What limitations in the child's participation are due to the handicap?

____

3. What modification of activity or equipment, if any, was necessary to meet needs of child?

____

IV. Peer Relationships (Initial and current if changed)

1. How does the child relate to other group members - handicapped and non-handicapped? Include any friendships he has formed.

____

2. What is the attidude of other children toward handicapped child? ______________________________

3. What role does child play in group? ____________________

V. Other Observations

1. What are the child's relationships, attitudes, and behavior within the center apart from his group activities?

____

2. Did the child seem to enjoy himself when observed?

____

3. Use three words that best describe child.

______________ ______________ ______________

4. In what ways does the child's behavior reflect increase (or lack of increase) in his self esteem?

____

NEW YORK SERVICE FOR ORTHOPEDICALLY HANDICAPPED

Department of Community Services
853 Broadway
New York, New York - LF 3-4020

I would like my family to participate in the research project being conducted by the New York Service for Orthopedically Handicapped. I understand that this project is for the purpose of studying the adjustment of handicapped children in order to find the best kinds of experiences that will help them in their development. I further understand that at various times during the next two-years the New York Service for Orthopedically Handicapped will visit my home for the purpose of conducting interviews with my handicapped child and other members of the family.

Child's Name ______________________

Signature of
Parent or ______________________
Parents ______________________

______________________ (Interviewer's Name) ______________________ (Date)

/es

"Pioneers For 60 Years"

NEW YORK SERVICE FOR ORTHOPEDICALLY HANDICAPPED

Department of Community Services
853 Broadway.
New York, New York 10003 - LF 3-4020

Dear ________________________:

Enclosed you will find a medical release form which the New York Service requires. This form will be sent from the New York Service to the hospital which your child is currently involved with.

Please fill out the form in this manner: "I hereby authorize," ________________ (fill in the name of the hospital); ..."Information pertaining to," ________________ (fill in your child's name; "signature" ________________ (mother's name).

Please return this form to the New York Service's office to my attention. Also, include on the form your clinic number at the hospital. If you have any questions concerning this form, please call me at the New York Service office.

Sincerely yours,

:cc
Enc.

NEW YORK SERVICE FOR ORTHOPEDICALLY HANDICAPPED

853 Broadway - New York, N.Y. - LF 3-4020

CAMP OAKHURST - OAKHURST, NEW JERSEY

I hereby authorize ____
to release to the NEW YORK SERVICE FOR ORTHOPEDICALLY HANDICAPPED, information pertaining to ________________________ condition while under your care.

Signature ________________________

____

"Pioneers for 50 Years"

REQUEST FOR MEDICAL INFORMATION

RE:

Name____________________Sex_____Age____Birthdate_________________

Address______________________Zone____Boro__________Apt.___________

Father's Name_______________________Mother's Name_________________

Kindly complete the following portion of this form:

Supervising Physician:_______________Date of child's last visit:___

How long known to you:_______________Name of Clinic:______________

Social Worker:____

Diagnosis:____

Date of onset of disability:_____________________ Description of physical disabilities:_______________________________

What is your estimate of applicant's intellectual ability?_________

Are there any contraindications regarding physical/recreational activities outside of the home for this child?____________________

OTHER COMMENTS: (social maturity, personality, etc. of child; parent-child relations; parental attitudes)

Date:_________________ Name & Position of Person filling out this form:

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